March 1961

Mental Hospitals

Hospital Journal
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NURSING

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WITH
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MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.

TWO ROADS TO TREATMENT

The psychiatric hospital or the psychiatric unit in a general hospital—which is the better place to treat the mentally ill patient? In the following section two authors present their views as to how the question should be answered.

I. The Case for the Psychiatric Hospital

By GEORGE J. WAYNE, M.D.
Director, Edgemont Hospital
Los Angeles, California

I CAN ASSUME, I am sure, that we all agree that there is abundant need for the services offered by both the psychiatric ward of a general hospital and the specialized facilities of the psychiatric hospital. No one among us wishes to convert this discussion into a debate—and if, in what I have to say, I seem to structure my points within the pro and con conventions of the debate, I do so for purposes of emphasis, not with the intent of belligerence.

We all recognize that there has been a very marked trend in recent years toward accepting the psychiatric ward in the general hospital as the solution for the never-quite-solved problem of hospitalizing the psychiatric patient. In many ways, this relatively new approach is a very good one—realistic, workable, convenient—but perhaps more convenient to the medical profession than to the patient. However, in our eagerness to foster this trend, some of us lose sight of the very real and quite unmatched advantages offered by the specialized psychiatric hospital.

It is on the unique function of this type of hospital that I want to focus attention. I am advancing nothing on an either/or basis. Many of the advantages which I attribute to the specialized psychiatric hospital are shared—more or less—by the general hospital, and many of the shortcomings which by implication I ascribe to the general hospital occur, of course, in many specialty hospitals too.

With these disclaimers behind me, I'd like to anchor this discussion to this major premise: the total climate in the psychiatric hospital—professional, social, interpersonal—is uniquely oriented to the reclamation of the psychiatric patient in a way which is not possible in any other kind of treatment setting.

In documenting this premise, some of what I have to say applies to all psychiatric hospitals, and some of my supporting evidence will, understandably, be drawn from the psychiatric hospital with which I have had most extensive direct experience—the private hospital which I serve as medical director.

Ordinarily, the psychiatric hospital can accommodate a wider range of psychiatric patients than can the general hospital. The specialized hospital can take care of both the short-term and the long-term patient—the acutely agitated patient as well as the mildly disturbed one. Many general hospitals simply cannot admit the acute psychiatric patient, because they do not have the specialized facilities which are often required for the treatment of acute illness. In other general hospitals, the acute psychiatric patient may be admitted, but in the very defensible interests of the total hospital operation, he must be isolated in what is virtually a padded-cell environment.

In the specialized psychiatric hospital, these acutely ill patients are considered part of the normal patient traffic. They are expected; they can be cared for; they can more often than not be helped. They can be admitted on an emergency basis at any hour of the day or night, without the delays of red tape. Very often their own survival, or the safety of their family may depend upon this immediate care. In short, the specialty hospital is more accessible to the psychiatric patient than is the general hospital.

Once admitted, the acutely ill patient can be taken

Read at a symposium on mental hospitals, at a meeting of the California Hospitals Association, Yosemite, October 1959.

care of more flexibly in a private psychiatric hospital than he can in a general hospital. Let me tell you how we handle him at Edgemont. We have a security wing, in which we exercise the usual precautions—no matches, no sharp instruments, no breakable mirrors, maximum supervision during mealtime and bathing. But within these restrictions, the acutely ill patient has quite a range of activity. The assumption is that the patient is going to improve, and as he does, his range will expand and the restrictions will be removed.

FREEDOM OF MOTION

These patients are not locked into their rooms; they are free to mingle with other patients in the wing if their condition permits them to benefit from contact with other people. They can spend time in a lounge area, watching television. They can have books brought in from our library. They can go outside into a private sheltered patio, where they may join other patients from this wing in meals or games. The door to this patio is always unlocked. These patients are not penned up.

They can, with the approval of their attending psychiatrist, have visitors. They can, as they show evidence of recovery, begin to share in a controlled way the life and activities of the less disturbed patients in our open wing. Perhaps they are ready for a trip to our beauty parlor, or can benefit from our occupational or music-therapy program, or are well enough to come into the dining room and take their meals with the other patients. The transitional steps from restrictions during the acute phase of the illness can, from my observations, be taken more realistically in a private psychiatric hospital than anywhere else, because the entire environment is geared to this type of progression for the patient.

So much for the acutely disturbed patient. What of the other types of patients who are hospitalized for psychiatric illnesses, those who are at no point cut off completely from the outside world but who are, in effect, chronic—that is, who will need some continuing support.

Such patients feel at home, feel comfortable and "belonging" in a psychiatric hospital in a way that can rarely be duplicated on a ward in a general hospital. The general hospital can't, in all good sense, give psychiatric patients the amount of freedom and mobility which can be offered them in a psychiatric hospital. Too often, the psychiatric ward is peripheral to the main business of the general hospital, or worse than peripheral, shunned and side-stepped. Such special activities programs as can be planned are of necessity quite limited, because the real business of the general hospital is going on in the surgery, on the O.B. wards, or elsewhere.

Such relationships as the patients may maintain with each other and with the outside world are also limited. Few general hospitals, even with the most advanced and admirably staffed psychiatric wards, have found it practical to develop activities programs as varied and extensive as most specialty hospitals can offer.

Again, I'd like to talk from my own experience. Edgemont is only one of many hospitals that offers the type of patient environment I'm going to describe. It may be unique in some respects, but fundamentally it adheres to a pattern which most of the newer private psychiatric hospitals are following.

I am talking now about patients on our open wing. These are fully ambulatory. They can and should have a certain amount of supervised freedom, with carefully scheduled projects to fill their time purposefully. All of this—the freedom and the projects, as well as what we are able to find out about them and their problems as they react to freedom and to activity—is done under the supervision of each patient's attending psychiatrist.

Patients at Edgemont are not restricted to their rooms. The whole hospital is open to them. They share many of their waking hours with other patients, and this means companionship and much more. If often means the exchange of understanding and support. It may mean help given as well as help received—and the immense therapeutic value that comes from assuming a helping role. Patients eat their meals together, and share, as much as they like or are able, our social and recreational programs, our occupational and music therapy, our field trips.

Most psychiatric wards in general hospitals have some form of occupational therapy, and many of them have also introduced music therapy. Many of them plan off-grounds excursions for their patients, and some of them offer a recreational program. But how many general hospitals have the space, the special facilities, and the staff for a really full-scale activities program?

At Edgemont for example, the occupational therapy program not only includes the usual arts and crafts, but also extends to the publication of a weekly patient newspaper, the *Forward Look*, a four-page, mimeographed, engagingly nonprofessional publication. Obviously, this type of project calls for special equipment and more space than could be available on the average psychiatric ward.

SOCIAL ADJUSTMENT

Or, to cite another example, we give our patients the opportunity, once a month, to see how well they measure up in terms of the demands of a social situation. We give a dress-up party for patients, their families and friends, and our whole staff, doctors included. Parties, of course, are given almost everywhere, but at best it's just a make-believe party which is simply given by opening up the connecting doors between a couple of wards and pushing the beds out of the way. But when you have a spacious recreation area that combines with your dining area, and when you can have the orchestra play and the guests dance without worrying about disturbing postoperative patients on the floor below, it starts to feel like a real-life party.

Everything about our activities program—our field trips which are particularly varied because Edgemont is located in the heart of the metropolitan area, our showings of films dealing with the problems of mental illness, our group discussions, the choices patients have among outdoor sports and indoor games—is abundant and untrammeled, with suitable and adequate equipment, because providing that type of supportive environment is our primary function.

What's more, we offer this type of environment as a part of the continuing treatment for outpatients. We have faced the reality at Edgemont, as have most psychiatric hospitals, that discharging a patient must, in many instances, be a highly tentative, experimental undertaking. And so we have made provisions for various modifications of an all-out discharge. Almost all patients, of course, continue their psychotherapy after they leave the hospital. In addition, it is possible for some patients to return to their homes but to continue to receive day care from us, participating in occupational therapy, music therapy, and various forms of socialization. Patients in other circumstances with other types of needs can resume their work life and return to the hospital for night care.

HALF-WAY HOUSE

We have also provided a new and enormously important type of continuing care. We have inaugurated, immediately adjacent to Edgemont Hospital and completely integrated with the hospital facility, a half-way house for the patient who has no home to return to, or who, for reasons directly connected with his illness, should not return home but is able to leave the hospital, go back to work or to school, and in many ways resume a normal life.

Such a patient, partly recovered but still in need of some support or at least some ties to a familiar and secure life, can live in his own apartment, come and go at will, take up as much or as little as he can of the life from which he once retreated. But he is never made to go it alone beyond his own strength. He takes his meals with other ex-patients; he shares in parts of the ongoing patient program if he wants to. He has a degree of psychotherapeutic supervision, and treatment and help are immediately available if he finds he has overestimated his own emotional strength.

I have stressed, so far, the areas of difference between the psychiatric hospital and the psychiatric ward of a general hospital in terms of environmental advantages to the patient. I am assuming that psychotherapeutically the patient receives equal treatment in either type of hospital, because we are talking only about thoroughly qualified hospitals. I think, however, that we might touch on the ancillary services which the psychiatric patient often needs—medical and surgical care, diagnostic facilities, and so on.

In theory, the availability of such services is one of the major advantages of hospitalizing the psychiatric patient in a general hospital. Certainly the full range of medical services, including all specialties and all diagnostic facilities, is available at such a hospital. I have found, however, that in some of the larger general hospitals, medical services for the psychiatric patient are sometimes not so readily available as one might imagine. Large hospitals—and I certainly don't have to labor this point—aren't always the most flexible of institutions, and, let's face it, physical illness among psychiatric patients often seems to be not quite so much of an emergency as it does among the newly admitted, acutely physically ill patients in the medical and surgical wards.

I mention this only as the reflection of an underlying attitude—certainly not as an accusation. But I do know that it is entirely possible to give immediate medical attention in a psychiatric hospital. We do it at Edgemont, with our own laboratory, and with a group of medical and surgical consultants on 24-hour call.

The subject of nursing care also warrants mention. The nurse who takes care of psychiatric patients in a specialized hospital is, in effect, on the major service in that institution, and this tends to be reflected in her attitude toward patients. The nurse in a general hospital who is assigned to the psychiatric ward may have quite a different attitude. She is, so to speak, out of the mainstream. She rarely considers her assignment a "plum"—you know, she's off there with those crazy people—and this, too, is reflected in her attitude toward the patients.

Incidentally, we are learning more and more about the specialized talents of a good psychiatric nurse as we give her the opportunity to work in specialized hospitals. I think it cannot be argued that for this particular type of nursing assignment much of the formal training of the nurse is quite wasted—her knowledge of surgical nursing, her experience in obstetrics, in anesthesiology, to name only a few examples. On the other hand, there is a real need for intensive training in interpersonal relationships, and more important, for a gift or talent in this highly sensitive area.

A word on the use of volunteer help might be germane here. Many general hospitals, particularly those supported by and integrated with religious groups, make generous use of volunteer help. There is, of course, a place for some volunteer assistance in a specialized psychiatric hospital, too. But I believe this is an area in which we ought to move with extreme caution. We use volunteers very selectively at Edgemont, for assisting in occupational therapy, or for accompanying a group of patients to a museum, for example. But we find, as some of you must have found, that many volunteers have needs of their own that are quite as urgent as our patients' needs, and that involvement between patient and volunteer, except on the most superficial level, can do infinitely more harm than good to both of them. Somehow, the typical volunteer—full of good will and compassion but not always endowed with insight—often can't resist the impulse to do oh-just-the-tiniest-bit of innocent misguided counseling—and that's where we draw the line at Edgemont.

FOCUS ON THE PATIENT

By way of summing up, then, the case for the specialized psychiatric hospital can be stated in these terms: in such a hospital, every facility, every program, every staff member, nonprofessional as well as professional, functions solely in the interests of the psychiatric patient. That patient is the hub of the wheel. All of its spokes are pointed inward toward him—his well-being, his needs, his recovery. The nurses at a specialty hospital such as Edgemont are there because it is the service of their choice—and future nurses, now training at Los Angeles City College, do their psychiatric service with us. The occupational therapist, the clinical psychologist, the

psychiatric social worker—each is concerned exclusively with the problems of the psychiatric patient. The internists who serve as our consultants are especially interested and especially qualified in the medical problems of the psychiatric patient, and since many of them maintain offices in the medical center which is part of the hospital structure, they are always available. Our physiatrist has planned his physical rehabilitation department entirely in terms of benefits to psychiatric patients. The attendant in our beauty parlor, the cooks, and the girls who serve the meals, the gardeners, and the maintenance men—everybody on the premises has a common assignment and a common goal: helping the psychiatric patient.

The hospitalized psychiatric patient needs more than his daily hour of psychotherapy. He needs more than rounds of tranquilizers and sedatives. While he is being treated, and, in fact, as part of his treatment, he needs a substitute home where he can have a measure of privacy, to be sure, but where he will also have interests, commitments, even responsibilities, that will give him a sense of being part of a world outside himself. And he needs, too, a substitute family, to give him understanding, help, guidance and love. These are complex, delicately balanced needs. Meeting them should not be an incidental assignment, nor a by-product activity. It should be a primary function. In the specialized psychiatric hospital, it is.

II. The Case for the Psychiatric Unit

By JOSEPH T. GRECO
Associate Director
Barnes Hospital
St. Louis, Missouri

LITTLE BY LITTLE psychiatry is achieving its goal of becoming a community concern. It is also developing closer working relationships with other branches of medicine and with surgery. As a result, greater emphasis is being placed upon the general hospital as a proper facility to render diagnostic and therapeutic services to the mentally ill. This is not surprising, for it is in the general hospital that frequent mutual referrals, consultations, and consortia become the media for psychiatry's best collaboration with the other medical specialties.

It will not be an easy task, of course, to put psychiatric services into every general hospital. Nor is this article intended to be the last word in formulating a permanent role for either the general or the psychiatric hospital in treating mental disease. I suggest, however, that the difficulty in establishing psychiatric units in general hospitals will diminish as private psychiatric practitioners increase. And they are bound to do so, if for no other reason than the professional satisfaction that is to be gained through the practice of their specialty in the atmosphere of the general hospital. Recently-trained psychiatrists find a particular appeal in being able to study, care for, and treat psychiatric patients on the individualized basis long familiar to practitioners in other specialties of medicine; they question the efficacy of one doctor's treating large numbers of patients—a common practice in the isolated psychiatric hospital. Their desire to give individualized treatment, and the opportunities that are open for them to do so, invite the marriage of psychiatry to the general hospital.

The addition of psychiatric units has dramatically affected the growth and improvement of general community health centers. It has wrought a changed public attitude toward voluntary admission and prompt hospitalization for the acutely ill. Today general hospitals admit more patients with a wider range of diseases than they ever have before. Longer periods of stay—if not total stay—are being sanctioned for persons afflicted with acute and subacute mental diseases. Because of these and other changes, progress is being made in treating mental illness more effectively.

Of course, part of the increasing success of treating psychiatric disorders in the general hospital is due to chemotherapy, but a still larger portion is due to the combined skills of attending psychiatrists and consulting physicians. Basic and clinical researchers in psychiatry have developed new concepts and better techniques which increase the competency of psychiatric practitioners. Now, with the allocation of teaching beds in general hospitals, interns and residents in psychiatry—like those in medicine and surgery—are acquiring new experiences and skills which are necessary to intensive therapy.

Despite these tremendous advances, however, we have not entirely eradicated society's fear of mental illness. Therefore, it is understandable that relatives—and perhaps some of the patients—cling to the unexpressed hope that an affliction manifested as mental illness may be attributed to a remediable physical disease rather than to a psychiatric disorder. The validity of this hope can be determined readily in a general hospital where the patient's illness can be studied immediately and intensively by a variety of specialists who have complete diagnostic facilities available to them.

Mentally ill patients and their relatives, having seen modern medicine's triumphs over physical ills, also

take hope in realizing that the general hospital is a place from which return to normal living is a usual occurrence. The psychiatric patient who accepts the principle of voluntary admission enters the general hospital without the shame, fear, or stigma that often plagues him upon entering a mental institution. Psychiatric patients in general hospitals remain in close contact with their families and friends; they receive the visits, ministrations, and attention of their chosen physicians, as well as of a variety of specialists. These factors make a big difference to the morale of the patient and his relatives.

So far, I have broadly outlined advantages to be gained by adding psychiatric units to general hospitals. A review of activities in the Renard Psychiatric Unit of Barnes Hospital in St. Louis will help to make the point more specifically.

Barnes is a teaching hospital, affiliated with Washington University. It is completely departmentalized, both physically and functionally, and possesses all of the facilities and services listed by the guide issue of HOSPITALS, the journal of the American Hospital Association. It is fully-accredited by the Joint Commission on Accreditation of Hospitals, and its intern and resident training programs are approved by the American Medical Association. The chiefs of Barnes' general and specialty clinical services are professors in the Washington University School of Medicine.

The Renard Unit is equipped and staffed to accommodate patients suffering the widest range of psychiatric disorders. It provides services for the short- and long-term patient, the acutely agitated, and the mildly neurotic.

The psychiatric staff alone, for the 106-bed unit at maximum occupancy, averages almost one doctor for every two patients. Obviously, the ratio of doctors to patients becomes much greater when one considers the total staff of Barnes Hospital in relation to Renard's bed component. This provides for more thorough care than can be given in hospitals where the ratio is reversed—and often greater—or where the therapeutic physician is made responsible for larger numbers of patients.

STAFF RESPONSIBILITIES

Renard's medical staff is composed of the university's full-time attending staff, the private part-time attending staff, and the resident staff. Each of these staffs is responsible for patient care, teaching, research, and learning.

The full-time staff, which has offices in the medical center, is primarily responsible for teaching residents and medical and paramedical students of the university and Barnes Hospital. Its members supervise the resident staff's clinical practice and conduct a large portion of the basic research program. They also have the privilege of hospital appointment in caring for private and semiprivate patients, as do attending staff physicians. Fees for services rendered to such patients are turned over to the medical school's department of psychiatry, and are used to pay the salaries of the full-time staff.

The private, part-time attending staff, which has offices outside the medical center, shares the teaching responsibilities of the full-time staff. Its members receive professional fees for their treatment of private and semiprivate patients.

Renard offers a three-year resident training program, with a fourth year for those interested in the position of chief resident or specialization in child psychiatry or various phases of research. The chief resident is administratively responsible for his staff, and arranges for the admission of Renard's ward patients, who are referred to the hospital by practicing physicians, community agencies, or the university clinics. These patients are not charged for treatment by the resident staff, and the hospital charges them less than the per-diem cost for its services.

ADMISSION PROCEDURES

Emergency services are available for all classes of psychiatric patients twenty-four hours a day, seven days a week. During evening and night hours patients are received and examined in the emergency room. A report of this examination is given to the referring doctor.

If the referring physician is not a psychiatrist, or if further therapy or hospitalization is indicated, consultation or referral to a staff psychiatrist is requested. The staff psychiatrist prepares further instructions and sees that they are followed through.

Four separate offices handle admissions for the medical center's seven units. Psychiatric admissions are processed in the Renard Unit. The patient, depending upon his condition and degree of personal insight, may either admit himself voluntarily, or be admitted involuntarily by relatives or friends. A resident staff doctor is promptly assigned to him, briefly examines him and gives written orders for his immediate care. Then the resident physician extensively interviews the patient's next-of-kin or the person who accompanied him to the hospital. When this interview is completed, the patient is given a comprehensive examination.

In the case of a private or semiprivate patient, the assigned resident contacts the attending physician for mutual exchange of information and issues any further instructions which grow out of this contact. Ward patients remain under the active control of the assigned resident.

During a patient's admission to Renard, he receives the usual general-hospital laboratory check-up, a routine chest X-ray, and any other diagnostic examinations the attending physician may prescribe. Facilities and services such as psychological testing, electroencephalograms, medical and surgical specialty consultations, and anesthesiology are immediately available to the psychiatric service. Occupational therapy is provided on a prescription basis. Recreational activities are voluntary, and social service workers are called in whenever there is a need for them.

Three of Renard's four nursing divisions are unlocked. There is one maximum security division for patients who are passing through the suicidal or acute agitation phase of their illness. A roof-deck provides the advantages of a sheltered patio. Each nursing division is equipped with shuffleboards, television, radio-phono-

graph, and a large day room where all patients take their meals.

Upon orders from their attending physician, all patients, including those of the maximum security division, have more or less complete freedom of movement. Patients of "open" divisions may leave the floor to go to the drug store, beauty parlor, or barber shop. Some have escort orders; others have complete hospital privileges. Maximum-security patients are always accompanied by an escort when leaving the floor.

The Renard activities therapy department, through its individualized or group activities, is an active adjunct to the professional services in the various therapeutic programs. Activities range from those in a complete occupational therapy department supervised by a staff of four therapists and two aides, to those in a flexible and extensive recreation department, which has two professional leaders and three aides. Patients go to occupational therapy daily on a prescription basis, are offered two programs which run concurrently during the afternoon, and may participate voluntarily in the evening recreational program.

The occupational therapy department is located in the hospital building in an area apart from the nursing divisions. Its physical facilities offer patients every opportunity to accept responsibility, to express self-assurance and creative impulses, and to release excess psychomotor energy. The department contains a complete kitchen, family laundry, and other homemaking devices for the patients' use. There is equipment for ceramics, painting, woodworking and other manual and graphic arts. Some activities call for group identification, socialization, and personality evaluations. Therapists observe the patients' emotional attitudes, physical reactions, and work habits, and report them to the medical staff every week by means of notes in the medical records or by conferences with the resident staff.

VOLUNTARY RECREATION

Renard's recreational activities program encourages voluntary patient participation. Although therapy is not specifically applied, the program's effect on patient development is definitely therapeutic. With the approval of their attending physician, patients participate in auditorium activities, ward activities, trips beyond the campus, and special projects. Auditorium programs, conducted two or three evenings a week, include volley ball, badminton, shuffleboard, body conditioning, etc. Folding chairs and portable stages adapt the facilities for parties, dances, live entertainment, movies, panel-quiz programs, and other group activities.

Ward programs, which help to counteract patients' reluctance to attend auditorium events, have become a regular activity. Recreation personnel visit each nursing division weekly, and conduct such favorite activities as group singing, dancing, and various quiet games.

At least once a week the recreation department arranges "out-trips"—industrial tours, museum visits, sports events, theater parties, picnics, walks in the park, and so forth. This type of group activity is the department's main concern. However, it also fulfills the patient's need for personal recognition by encouraging him to participate in special projects such as typing, assisting with party decorations, serving refreshments, and reporting for *Renard Hi Lights,* the patients' weekly newspaper.

There are those who question the quality of nursing care in a general hospital's psychiatric unit. I would like to point out that nurses are chosen very carefully for duty at Renard. They must indicate and possess an aptitude for, an interest in, and a desire to do psychiatric nursing. Many Renard nurses are university students working toward bachelor or master degrees. Students at the Barnes Hospital School of Nursing are given 13 weeks of psychiatric duty as part of their training.

This general description of the program at Barnes Hospital has been included to point up some of the values most likely to be gained from a psychiatric unit in a general hospital. Psychiatry alone cannot handle all of the problems which face it. It is unfortunate, therefore, that administrators of mental and general hospitals continue to engage in controversies involving questions of competition and values in services rendered. These continued unstructured controversies during psychiatry's current productive evolution appear to be ill-advised, and reap only incalculable losses to the profession, to the patient, and to the doctor. The significant factor in successful therapeutics for the psychiatric patient rests in the doctor-patient relationship. This should be so whether the patient is in a general hospital or in a mental institution.

Self-Responsibility For The Mentally Deficient

By MATTHEW J. KRAUS, JR., Ph.D.
Oregon Fairview Home
Salem, Oregon

IN AN INFORMAL EXPERIMENT, 300 mentally deficient patients from Oregon Fairview Home assumed responsibility for their own welfare and behavior while living in a vacation camp for two weeks last June. For some, it was only the first or second time they had been outside an institution in years—for all, it was a unique experience. The patients shouldered their new responsibility with eagerness and with a competence that surprised many of the staff, and no serious patient-management problems arose despite a minimum of regimentation and supervision.

The camping experience showed there may be too much concern about the inability of the mentally deficient to make simple decisions for themselves. With proper guidance, many of the regimented activities on hospital grounds could be made the responsibilities of the patients. Of course, the choice of patients for such responsibility-taking is a matter to be considered carefully and there must be adequate staff ready to "come to the rescue" if a situation becomes too complicated.

WHY HAVE SELF-RESPONSIBILITY?

Oregon Fairview Home is the state's only institution for the mentally deficient. It cares for approximately 2,600 patients, and the problems of housing, feeding, and clothing such a large population necessitate regimenting many patient activities. Times are specified for arising, going to bed, eating, working, bathing, and for numerous other details of institutional living. However, in such an atmosphere it is difficult to develop self-reliance in patients, and there is always the question, "Can certain patients assume responsibility for their own care and maintenance if they are given the opportunity to try?" Consequently, a summer-camp program was planned, partly as a vacation for patients, but also to find an answer to the preceding question.

Between June 20 and July 1, 1960, some 300 male and female patients, between 18 and 35 years of age, were taken to a nearby state park in two groups of 150 each week. In a representative sample of 27 patients in the group, IQs ranged from 24 to 92 with a median of 49. However, over two thirds of the IQs were between 41 and 64.

The living arrangements at the park differed drastically from those to which the patients were accustomed at the home. At camp they were awakened at 7 a.m. and breakfast was served at 7:30. If a patient wanted to sleep a little longer, he was allowed to do so. During the day there was little regimentation. At mealtimes a bell was rung and the patients came to the dining room of their own volition. As little work as possible was required of the patients, but they reacted to this by volunteering to help. Going to bed at night was, in a large measure, left up to the patients, and they usually retired at a reasonable hour. Throughout the two weeks, nightly bed checks were made and not a single case of absenteeism was reported.

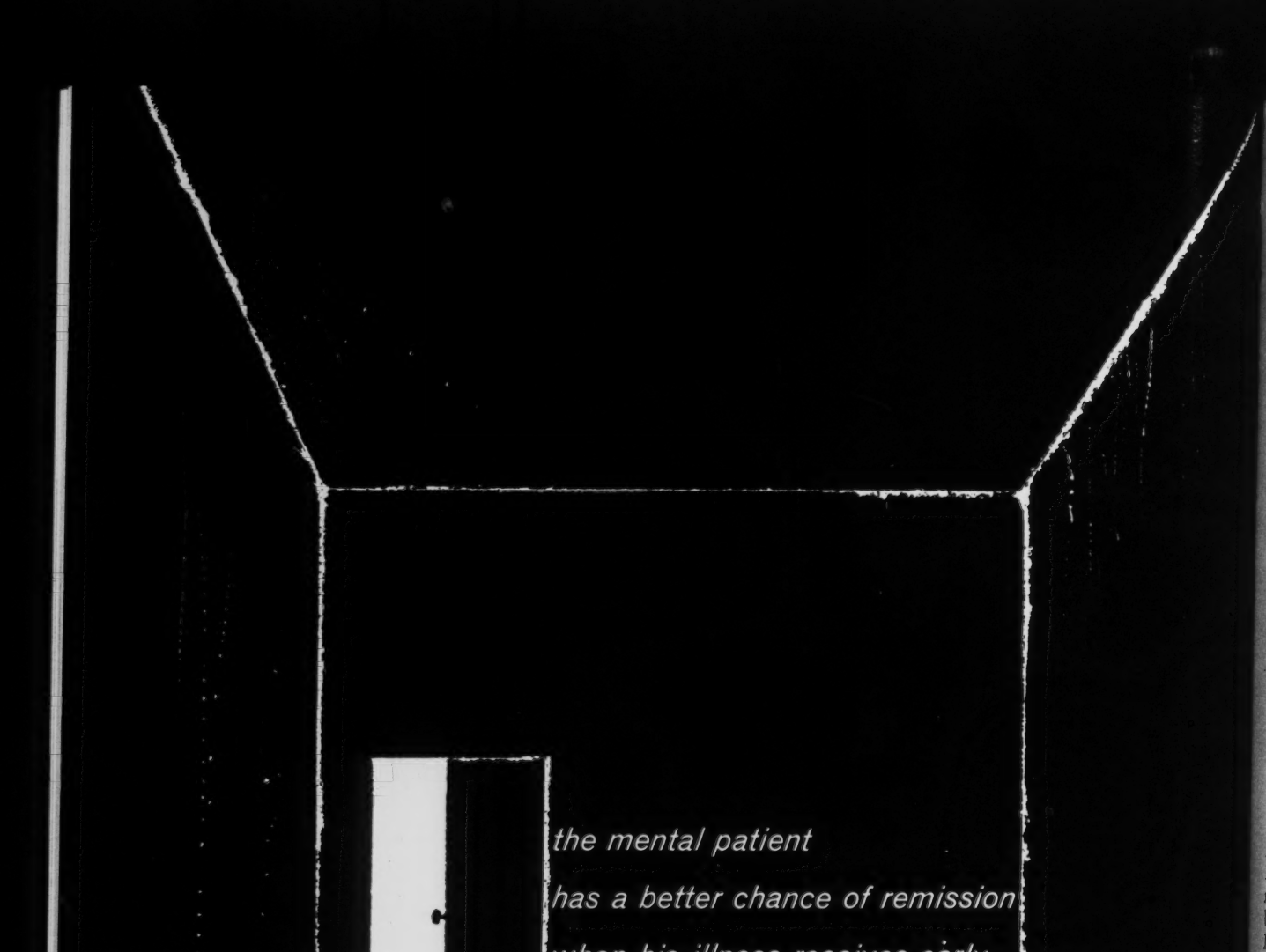
As far as can be determined, there were no serious problems with male and female patients living in close proximity to each other, mixing throughout the day, and eating their meals together. However, on several occasions individual patients needed to be reminded that there were certain rules of behavior to be observed when associating with the opposite sex.

PATIENTS REACT FAVORABLY

The most important question to be answered in evaluating the camp experience is, "How did patients react to the increased responsibility which was given to them?" On the basis of staff observations, it would seem that the great majority of the patients welcomed the opportunity to make simple decisions for themselves. In one week of camp, the writer heard only one minor murmur of discontent from a patient; but to assess the patients' feelings more objectively, a study is now being made of questionnaires that were filled out by the patients before they went to camp and again after their return.

Generally, patients liked being able to come and go as they pleased and enjoyed the almost complete lack of regimentation. They also showed a desire to work in order to demonstrate their ability to use this added responsibility. The reactions of one 24-year-old male patient who is mildly deficient were typical. He felt free to do pretty much as he pleased, and expressed this feeling on several occasions. Yet he was one of the best workers in the camp and needed only occasional directions from the staff. This man has been institutionalized for 17 years!

Necessary activities, such as bathing, house-cleaning, etc., were quite often accomplished by patients with a minimum of supervision or direction from staff. All patients kept themselves clean and well-dressed, and the camp units were orderly and well-cared for. Thus it appeared to the staff that the majority of patients relished their new responsibilities and felt a certain sense of duty to live up to the expectations of the personnel. •



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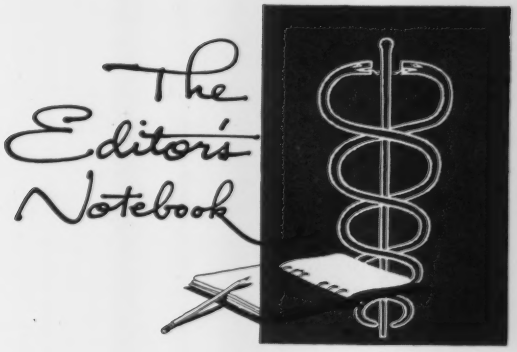
Guest Editorial

Mr. Robert L. Robinson, Public Information Officer of the American Psychiatric Association, has been serving in that capacity since 1948. This month's Notebook is based on a talk he gave to the Fifth Annual Conference of the Department of Mental Hygiene and Hospitals at Roanoke, Virginia.



IT IS ALTOGETHER AUSPICIOUS that several state mental health and hospital systems are adding full-time experienced public relations people to their staffs. The rapid unfolding of integrated hospital-community treatment programs for the mentally ill makes skilled public communication more vital to progress than ever before.

Curiously, it has taken a long time to alert the mental health disciplines to the value of the PR man in program development and administration. Most state departments of mental health now have at least one staff person assigned to full- or part-time public relations duties, but almost never do they carry a public relations title. If they are full-time, they are called, variously, Chief of Publications, Director of Editorial Department, Mental Health Educator, Information Officer or Specialist, Director of Public Education. The part-time person may be an Assistant or Deputy Commissioner, a Chief of Psychology or Social Work, or almost anything. The mental hospitals themselves seldom have a PR man, or if they do, he is even more carefully disguised. Why this blurring of the image of the PR man? Several reasons suggest themselves.

Perhaps it is because, unlike the doctor, nurse, psychologist, and social worker, the PR man is not the product of a well-defined course of training. As a rule he is a university product, but he may emanate from almost any academic department. About all we can say with conviction about his training is that he must be generally well-informed and specifically skilled in communications.

Some professional people raise an eyebrow at what they consider to be the PR man's "ghostly qualities." He is supposed to be an "image builder." He is a "cover man" to explain away unpleasant facts. He is a "gimmick" manufacturer and a "fund raiser." The legislator may view him as an enemy agent whose only purpose is to extract more tax money for the entrenchment of bureaucracy. The professional person sometimes has the notion that the PR man wants to speak "for him." (How could he do that without training in medicine, psychiatry, social work, psychology? they ask.)

All of this, of course, falls short of the mark. The point is that the PR man—whatever we may call him—is expert in processing communications between those who originate the subject matter (doctors, nurses, social workers, for example) and the various publics who are to receive it and understand it. However well-informed he may be, he need not be and usually is not expert in the subject matter he communicates. He does not speak for or in place of the professional; he helps the professional to speak for himself.

One may hope that the occasional legislator's view of the PR man as a trickster will quickly give way to the more statesmanlike concept that a public service agency, such as a state mental health department, has a moral obligation to present the best possible case it can to obtain adequate funds to carry out its public responsibility. Such clarity is not possible without processing through the hands of a communications specialist the complex data that is pertinent to building the case. Someone must convert the dreary statistical tables into charts and graphs that can be understood. Someone must translate the jargon-loaded reports of the professional into the mother tongue.

The PR man is no ghost. He is a stark reality, indispensable to the functioning of a highly technological society in which it is no longer possible for policy makers and leaders personally to receive, digest, and transmit the vast amount of data that must be processed in and out of their offices.

Mental health workers have come a long way—with the help of journalists and PR people in various disguises—in convincing the public that mental illness is truly an illness to be treated as such, rather than something inflicted on us diabolically by chance. Now, however, the mental health professional is asking something more of the man on the street than that he be more generous with his pocketbook. The man on the street is being asked to entertain the notion that *he can relate to the victims of mental illness in a personal way* and thus help in achieving the therapeutic goal of recovery and rehabilitation. Is that not implicit in the wide range of community facilities that are projected as devices to keep patients out of and shorten their stays in the hospital? This is quite a package to sell! It will take some mighty skilled communications to do it. Public relations people must be called in to help. It doesn't really matter what titles are put on their doors, albeit it would be gratifying to have a rose be called a rose.

Robert L. Robinson

The White House Conference on Aging:

A REPORT ON THE MENTAL HEALTH GROUPS

THE CONVICTION that the community—given the facilities—can often deal best with prevention, treatment, and care of an aging individual's mental illness dominated mental health workgroup discussions at the first White House Conference on Aging. This conviction had also appeared many times in the 120 mental health recommendations submitted by 37 states for the delegates' consideration. As a result, it was prominent in the final recommendations prepared by mental health workgroups:

Mental health is adaptability to internal and external change, recognition of self limitations and potential and the maintenance of a variety of sources of satisfaction. Any condition that causes pathological changes in these areas can create mental illness in the individual regardless of age. To provide adequately for the mental health needs of older people consideration must be given to certain positive concepts.

a. The development of a public enlightenment program which recognizes that public attitudes toward mental health can and must be changed. This process of enlightenment should begin with the child in the family and continue throughout life.

b. That the mentally ill aged should receive service in the community from the same agencies and clinics serving other groups.

c. The aged should receive mental hospital service only when they are mentally ill and there are psychiatric indications.

d. Mental health services, inpatient and outpatient, should be organized to allow free movement of patients between services depending on treatment needs.

e. The community should provide a proper psychiatric evaluation of any patient prior to initiating commitment proceedings. If commitment is indicated plans should be started immediately toward return of the patient to the community. The procedure of commitment should not require a finding of incompetency.

f. Any plans which provide health care or assistance should not exclude the mentally ill. A percentage of all Federal Hospital Construction funds should be earmarked by the states for mental health facilities.

g. Extension of mental health services is dependent upon an adequate number of mental health personnel. Therefore, steps should be taken immediately to increase the number of trained personnel.

For months before the WHCA convened, January 9-12, 1961, the National Advisory Committee was absorbed in fashioning its program. Hayden H. Donahue, M.D., Assistant Superintendent, Arkansas State Hospital, was a member of the committee, and Mathew Ross, M.D., Medical Director, American Psychiatric Association, served as a consultant to it. The part of the agenda dealing with mental health was formulated by the Planning Committee of the conference's Mental Health Section, under the co-chairmanship of Drs. Donahue and Ross.

DISCUSSION TOPICS

The structure of the conference consisted of 20 sections grouped under 10 major headings, and divided into from one to four related sections. The 10 broad areas covered socioeconomic implications of population trends and inflation on the aging; health and medical care; social services; housing; education; the role and training of professional personnel; leisure time activities; religion; various aspects of gerontology; and local, state, service, and federal organizations and programs. In workgroup meetings, scheduled around three plenary sessions, ramifications of these general subjects were examined during detailed discussions.

Mental health problems in regard to the aging were the paramount concern of delegates assigned to Section 5, Health and Medical Care, workgroups D 1 through 4. Discussions focused on improving mental health and on the prevention, early detection, and treatment of mental illness.

Under the chairmanship of Dr. Donahue, one group discussed training and procurement of personnel, and explored preventive and extramural services for the mentally ill.

Another workgroup, chaired by Dr. Ross, discussed interdisciplinary approach, and the attitudes, information, and education necessary for public enlightenment about mental illness.

Gerald D. Dorman, M.D., Medical Director, Employees Welfare Dept., New York Life Insurance Company, led his group in discussing mental hospital care—admissions, laws pertaining to hospitalization, care, and discharge planning.

Rehabilitation and financing mental hospital care were considered by the group under the chairmanship of George W. Jackson, M.D., Director of Institutional Management, State Department of Social Welfare, Kansas.

PLAN FOR ACTION

The idea for the conference was conceived three years ago on January 8, 1958. At that time, John E. Fogarty, Congressman from Rhode Island, stepped forward to tell his colleagues, "There has been a great deal of talk about aging and what we need now is action." With these words he introduced the WHCA Bill.

He had seen what former White House conferences had accomplished by focusing national attention on the problems of children, young people, and education. The time had come to use this forum on behalf of the aging. Five basic problems urgently demanded attention: employment, income, housing, leisure time, and health. "It has long been my conviction," Mr. Fogarty said, "that the responsibility for meeting these challenges was primarily that of the communities and the states, and that the Federal Government should stand ready to work jointly with them and their citizens toward a common goal."

Between the initiation of the WHCA and its realization, each state was asked to review its particular problems in the field of the aging, and to compile a list of recommendations for the consideration of the conferees. Mr. Fogarty stressed his personal belief "that any recommendations or action must allow the older person's independent choice and create opportunities for self-help in planning his own future." This principle was repeated many times over in suggestions received from the individual states.

When preconference groups buckled down to their tasks, one problem besetting the elderly—good health, and how to pay for it—claimed a large share of their attention. Eventually, and not too unexpectedly, it ignited a controversy which had been smoldering fitfully for some time. Legislators, and others concerned with the nation's health and welfare, advocated Social Security financing of medical care for the aging. This position drew much-publicized criticism from the American Medical Association, finally uniting many AMA members in battle stance against the prospect of "socialized medicine." The press reported a plethora of charges that organized medicine had "stacked" WHCA proceedings against Social Security adherents, although the outcome of votes on the issue did not support these charges.

The conference was opened with some informal remarks by President Eisenhower. The 70-year-old President, looking jaunty and fit, referred to the delegates' purpose in convening, adding jokingly, "I don't want to get too definite about this aged business."

He expressed the hope that it would be a profitable conference "where every conceivable opinion, no matter how bitterly opposed it may be to some other opinion, will be fully aired, and out of your deliberations will come some kind of guidance that the Congress can use as it proceeds in its own deliberations later."

Other notables at the opening session included Arthur S. Flemming, Secretary of Health, Education, and Welfare; Bertha S. Adkins, Under Secretary of HEW; Pat McNamara, Senator from Michigan; and Congressman Fogarty.

Mr. Flemming reminded delegates that there are now some 50 million Americans who are middle-aged, and that nearly 16 million of them have passed their 65th birthdays. "We have not yet adjusted our sense of values," he said, "our social and cultural ways of life, our public and private programs, to accommodate the concerns of this vast legion of old and aging people. . . . The concept of the White House Conference recognizes that a climate for 'aging with a future' is the concern of everyone in our land, and all levels of our society should accept responsibility for action."

Senator McNamara used the occasion to give impetus to the controversial aspects of the conference by stating that in one workgroup "one out of every three delegates represents the medical or dental or insurance professions." He remarked that it was unfortunate that "the American Medical Association continues to devote such massive effort to the promotion of its Nineteenth Century philosophy rather than concentrating on the needs of today." More constructively, he reported that he had proposed an office of aging in the Department of HEW.

When Mr. Fogarty claimed the rostrum, he referred to the charges favoring one interest as "serious and insulting to those facing the problems of the aged." He said that he was introducing a bill for a Federal Commission on Aging, which would have independent status and report directly to the President and Congress. The commission would concentrate on research and not compete with other government agencies in the field.

WIDE PARTICIPATION

Despite this major conflict of interest between participating groups, the well-organized conference moved ahead to highly worthwhile consideration of its objectives. Eight Washington hotels overflowed with the 2,800 voting delegates, representing 300 national voluntary organizations, National Advisory Committee members, consultants to the 200 Planning Committees, each state, the District of Columbia, Puerto Rico, and the Virgin Islands. Additional delegates were designated by the Secretary of Health, Education and Welfare. Special invitations were sent to state governors, members of Congress, personnel of federal departments and agencies, and representatives of foreign countries.

A gratifying number of these delegates represented psychiatry or some phase of mental health work. In workgroup discussions they proved to be fully aware of the contributions they can and must make toward improving the lot of aging Americans. However, they also realize that such contributions are in jeopardy unless the urgent need for them is understood and supported by every citizen in every community. If the mental health group's final recommendations stimulate active programs toward this end, they will become—as their authors intended—outlines for progress. •

Higher Learning

FIVE THERAPISTS at the VA Hospital in Waco, Texas, are teaching adult patients everything from the Three R's to college mathematics, and from shorthand and typing to business law and salesmanship. These five, four with M.S. degrees and one engaged in graduate work, comprise the teaching staff of the Educational Therapy Section of the hospital.

The Veterans Administration began conducting adult educational programs for patients in its neuropsychiatric hospitals immediately after World War II. The program at Waco has been active for 15 years. It covers basic instruction for illiterate patients as well as for those with limited formal education, to provide them with reading and writing skills adequate for routine work assignments. The program also includes refresher courses in English and mathematics at both high-school and college levels for patients who have previously attained such levels but, as a result of illness or for any other reason, have a need to refresh their knowledge. These courses are also helpful to patients who have graduated from high school and plan to enter college.

Instruction in arithmetic science, and English are available for patients who require them in order to enroll in trade schools, and are a necessary part of the educational process of patients who are attending the hospital's various vocational programs and whose post-hospital goals are planned in the vocational fields. Organized classes are conducted in bookkeeping and accounting (beginning and advanced), office machines, typing, shorthand, business English, salesmanship, and business law.

End-of-course tests are administered by the therapists and sent under VA contract to the Extension Division of the University of Wisconsin for grading and issuance of completion certificates. These certificates are accepted at local business colleges and permit patients to continue to the next highest course. General Educational Development Tests are also administered. Patients who successfully complete them are eligible for a Texas Education Agency certificate, which is recognized as acceptable qualification for employment by Civil Service as well as by many other employers.

As in all the VA hospitals, educational therapy at Waco is one of the five major sections of the physical medicine and rehabilitation service, the others being manual arts therapy, occupational therapy, physical therapy, and corrective therapy.

WALTER L. FORD, M.D.
Director, Professional Services

Geriatric Activation Program

FOR SEVEN YEARS, Fergus Falls State Hospital in Minnesota has made a concentrated effort toward better programing for geriatric patients. Its facilities include four wards for senile patients, in the main part of the hospital, and two newer geriatric buildings which are designated as intensive treatment areas for three hundred men and women. Personnel have been assigned to the buildings by the recreation and occupational therapy departments to remotivate these patients, with the hope of their eventual discharge.

The most recent addition to the program is a new "activities" wing, which connects the two buildings. For the past few months, the recreation department has conducted scheduled, specific activities for the aged in the new unit and it has found that elderly people, as they learn routines, are more willing to participate in activities which they formerly considered "kid stuff."

On Monday through Thursday from 8:30 to 9:30 a.m. men patients come to the wing for remotivation activities. They begin with calisthenics and, after warming up, play such games as kickball, dodgeball, modified bombardment, rhythm games, and whiffleball. Over sixty men are brought in for the calisthenics, but when these are over, some of the men leave for occupational therapy, others are returned to the ward, and approximately thirty men stay for the activities. (All patients receive exercise, because they need some type of physical activity.)

The women arrive at 9:30 a.m. and almost 140 of them, as well as the personnel from their buildings, take part in the exercises. As with the men, the group is thinned down to thirty for more specific games or crafts, after limbering up.

On Friday mornings the patients from both buildings take part in an hour of singing, which they usually enjoy.

Afternoons are for more diverse functions: On Tuesdays there is a card and game session; on Thursday the activities vary from a Ladies Aid Group to birthday parties and dances; and extra activities and programs are conducted during the week by volunteer groups.

It cannot be stressed too often that, with routine and familiarization, geriatric patients do join in and enjoy things they may have avoided in the past. However, the initial effort in activating the patients is made through group prescription—the patients have to be brought to the activity whether they want to or not, just as in bathing, eating, or sleeping.

Through a good occupational therapy program, together with proper medications, good ward care and attention, and a well-rounded rehabilitation therapies program, the geriatric patients at Fergus Falls are being remotivated toward better mental attitudes.

LARRY ZAMBINO
Patient Activities Leader

A Patient-Sponsored Fellowship Club

By JOHN E. BROWN, M.D.
and J. HARRY FEAMSTER, Ph.D.
VA Center, Gulfport Division, Biloxi, Mississippi

DURING THE PAST SEVERAL YEARS the trend in neuropsychiatric hospital and ward management has been away from the strictly authoritarian rule of the custodian and toward the team approach of the therapeutic community. With this changing philosophy some very valuable and interesting by-products have developed. It is not the purpose of this paper to deal with the subject of the therapeutic community, as it has been extensively described elsewhere. We wish, rather, to report on what we consider to be an outgrowth of the new management philosophy.

In the "old days" when one was concerned about being attacked while walking through the wards, new personnel were told, "Don't worry about the patients attacking you in a group. They never do anything as a group on their own initiative." In the "old days" this was true not only of *destructive* behavior but of *constructive* behavior. Each patient tended to remain psychologically isolated from the other, and self-initiated group action by patients was unheard of.

Recently we at Jefferson Davis Hall have been delighted to see the exception to this rule unfold spontaneously on the part of our patients—a development of which we had no knowledge until so informed by the patient group.

In keeping with our belief that patients tend to improve when given appropriate responsibilities with adequate recognition for their performance, we submit the following paper. This article regarding the patient organization is transcribed as the former patient himself wrote it—without editing on the part of our staff.

THE FELLOWSHIP CLUB

In the last five years, it has become a growing tendency in mental hospitals to give patients more freedom and more responsibility in handling their own affairs. In B Ward, an open ward of the Gulfport Division of the Veterans Administration Center, two organizations illustrate these tendencies. One is the Therapeutic Community group, at whose meetings patients may criticize each other and the staff, and make recommendations for improvements on the ward. The other is the creation of the patients themselves to provide amenities not already available on the ward. This is the Fellowship Club.

Since its foundation in late January 1958, the Fellowship Club has found itself engaged in four major activities: Recreation, aiding indigent patients on the ward, helping patients leaving the hospital to find jobs, and repairing patients' clothing. The club gives a party at least once a month, usually attended by almost half the patients on the ward. These parties have always featured a dance whose music is provided by a small orchestra organized by the club. Refreshments are chosen and prepared by the joint efforts of patients and volunteer workers. In addition, one of the volunteer workers, using supplies furnished by the club, cooks doughnuts and distributes them on the ward at least twice a week.

Not only the parties, but two of the club's other major activities require the collection of donations for specific projects. These can be given at any time, but a table is set up when the patients receive their hospital allowances every ten days, so that active members may donate while they have cash in hand. From this completely donated fund—and no pressure is used to collect—five patients without money are given books of tickets each month which they can use in the canteen. During 1958, in addition, three indigent patients leaving the hospital were given sums large enough to sustain them while they began to look for jobs. By far the greater part of the club's funds, of course, goes for its parties.

The fourth major activity of the club is made possible by the assistance of ladies from the outside, mainly from the Auxiliary of the Disabled American Veterans of Biloxi. They spend all day each Wednesday in a sewing circle on the ward attaching buttons to patients' clothing and repairing them. All of these activities are carried out by a group of officers elected by all the patients, and the affairs of the club are conducted according to standard rules of order.

The Fellowship Club, which was founded and is conducted by patients for patients, has just completed a successful year providing recreation and services in the hospital which would not otherwise have been available. The club is an excellent example of how well the new trend in hospitals to give patients responsibility for themselves can work if given half a chance.

The patients have contrived to delegate their financial arrangements to trusted patrons of the club who are not connected with the hospital. They developed a complete accounting system, including regular inspection of their ledgers by the club's auditing committee. Social activities have been well planned and generally successful. Problems arising when responsible club members' mental illness exacerbated have been handled with considerable finesse.

As the development of the club progressed, its members met and dealt with any problems which they considered to be threatening to its financial and social independence. One current problem with which club mem-

bers are dealing involves conflicts between club social activities and Canteen Service concession rights. Another problem developed when the Hospital Finance Division, learning of the club activities, determined it necessary to take over and assume responsibility for the club's financial operation, which was, despite the patients' precautions, against existing VA regulations. At this point the patients availed themselves of consulting services in the person of the ward psychiatrist, who agreed to act as their intermediary. Contact was made with the director of professional services and the assistant manager. After further talks with the ward psychiatrist and with representatives of the club, the manager asked the VA Central Office for an interpretation of regulations to allow patient-contributions for specific projects. An affirmative answer was promptly received, and the morale and confidence of Fellowship Club members were considerably strengthened.

In conclusion, we believe that the spontaneous and unprompted creation of this valuable organization composed almost entirely of schizophrenic patients would not have materialized had we clung to the outmoded concept of our role as that of custodian. While the transition to a more modern approach to ward management seems to serve as a stimulation to the patient group, the reverse of this also applies. The patients' *esprit de corps* regenerates the ward team's enthusiasm and its spirit of initiative and enterprise.

Cooperative Recreation:

BRIDGE AND CHESS

AFTER HEARING PATIENTS COMPLAIN of the difficulty of finding a partner for chess or a fourth for bridge, the writer secured permission from the superintendent to organize a combined bridge and chess club to meet one night a month in the hospital auditorium. A telephone call to the president of the Wilmington YMCA Chess Club elicited an offer of help, and a few nights later three members of the YMCA group drove out to the hospital for the first meeting of the Delaware State Hospital Bridge and Chess Club.

For this meeting the auditorium was set up in four sections: one for those who already knew how to play bridge, one for those who played chess, a third for those who wanted to learn bridge, and a fourth for those who wanted to learn chess. Although the hospital club is now going into its fourth year, this plan has continued in effect.

The first meeting pointed up the need for expert instruction in bridge. Accordingly, the president of the Delaware State Bridge Association was invited to attend the second session. He came with one of his officers, and from that time on the YMCA Chess Club and the Delaware State Bridge Association have acted as joint sponsors of the DSH club, providing instructors at each meeting. The value of the sustained interest and cooperation of these two organizations cannot be overstated.

The state bridge group has also provided rotating teams of two instructors each for weekly on-ward instruction in bridge. Nearly 100 persons on 11 wards have learned the fundamentals of the game in this manner. Besides contributing a healthy increase to monthly attendance at the DSH Bridge and Chess Club meetings, this on-ward instruction has provided other benefits. A good many patients on each ward welcome the intellectual challenge of "the two hardest games." They enjoy the social atmosphere thus created, and they quite often develop sound friendships with their instructors. An all-male instruction team on the women's ward produced good results in learning, in the patients' personal appearance, and in the general appearance of the ward. Attendants, who originally regarded the experiment with suspicion, began to welcome the instructors and have the bridge tables set up for them ahead of their arrival. In two instances where it was feasible, men and women were combined in the on-ward classes. Again the results were good, both in re-awakened social consciousness and in improved personal appearance.

Since its first meeting in February 1957, the DSH Bridge and Chess Club has had an average attendance of 37, from a low of 28 to a high of 54. This may not seem many from a hospital population of 1450, but it includes most of those who are really able to benefit from the activity. Patients from six open wards are permitted to come to the evening meetings and return to their wards in a group without escort. This seems to have some fringe therapeutic benefits.

The experience of the DSH Bridge and Chess Club indicates that this type of recreation has considerable value for mental patients. Bridge and chess provide excellent exercise in concentration, good judgment, and self-control; they are pleasant outlets for self-expression and for both aggressive and social instincts; and they are stimuli toward wider and deeper living, away from unhealthy preoccupations and anxieties.

CORNELIUS A. TILGHMAN
Recreational Aide

OPERATION MIDDLEMAN

By ROBERT EDWALDS, M.D.
Department of Psychiatry
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How a state hospital outpatient clinic can fill the much-needed position of "middleman" between hospital, family, general practitioner—and the psychiatric patient

THE STATE HOSPITAL OUTPATIENT CLINIC can play an important role in the treatment of seriously ill psychiatric patients. The very fact that the clinic is directly connected with a state hospital allows it to offer the patient advantages that are found in no other type of clinic. Perhaps one of the most important of these is that this type of facility can give assistance or immediate hospitalization in time of emergency, when the patient's needs are greatest.

The Outpatient Clinic at Galesburg State Research Hospital* is a case in point. There is a full-time clinic staffed by a psychiatrist, a social worker, a secretary and (by referral) a part-time psychologist. It has two major functions: (1) to provide follow-up care for discharged patients; and (2) to evaluate and screen adult patients for admission to the hospital (children and adolescents under the age of 18 are seen by a state-operated traveling clinic). Partly as a consequence of its screening function, the clinic is also providing emergency, short-term casework; supportive psychotherapy; and drug therapy. This constitutes an effort to support the patient through critical periods and perhaps forestall the need for hospitalization.

HOSPITAL SCREENING

New patients from the community are seen in the clinic by appointment after referral from the family physician, and occasionally from the courts and police. Emergency evaluations can then be made the day of referral and, if necessary, the patient can be admitted immediately to the hospital. Ideally, under this system, very few patients should have to be committed to the hospital without first being seen in the clinic. However, an occasional patient will be unable or unwilling to come to the clinic, in which case regular commitment proceedings are followed. Fortunately, most patients can be referred directly to the clinic before they become so disturbed that they have to be brought into the hospital by force.

Usually, when families feel one of their members is mentally ill, they first contact the family doctor. He then, instead of sending them to the county court to file petition for commitment, refers them and the patient to the hospital outpatient clinic. If the relatives try to file a petition with the county court anyway, they are told that the patient must first be seen in the hospital outpatient clinic. Eventually it may even be desirable to have all admission procedures, including commitments, handled through the hospital. In fact, figures show that since patients can be referred to the outpatient clinic in the early stages of illness, approximately 75 per cent of those who are admitted to the hospital go voluntarily.

When the patient first comes to the clinic, he is examined by the psychiatrist. If possible, the social worker talks with the relatives, and if he is too busy, the psychiatrist sees them. Immediately after the new patient and his relatives have been interviewed the psychiatrist and the social worker discuss the case briefly and outline a tentative treatment plan. Even if the patient is to be hospitalized, plans for his eventual return to the community are discussed with the relatives. If psychological tests are indicated, the patient is tested within a few days and he then returns to the outpatient clinic the following week. Inasmuch as clinic time is not tied up with lengthy formal staff conferences, and scheduled appointments are not allowed to fill the entire day, time is available for handling emergency psychiatric problems, both for new patients and for discharged hospital patients. When time is available, the psychologist and social worker have informal conferences to discuss difficult and interesting cases. A few patients are seen for short- and long-term psychotherapy by the psychiatrist and the social worker.

The clinic operates with a minimum of formality,

*At the time this article was written, both authors were on the staff of the Galesburg Clinic, Dr. Edwalds as director and Mr. Paden as social worker.

but summarized records are kept up to date. The referring physician receives a copy of the psychiatric examination with recommendations for further outpatient treatment or for hospitalization. After the patient is discharged from the hospital, the family physician receives a report of the clinic's follow-up interview.

This system is beginning to function fairly well for the clinic's own county; however, the hospital serves a rather large rural area and it is difficult to screen patients who live over 50 miles away. When the patient lives more than 50 miles from the hospital, it might be desirable to conduct pre-hospital screening in the nearest community mental health clinic. The state hospital would then have effective liaison with the entire area it serves. Inadequate community welfare facilities, especially in the rural areas, make it difficult to refer patients and families in need of assistance but not in need of hospitalization. Because there is no community mental health clinic within this hospital's area, there is virtually no resource for long-term psychiatric treatment for the patient unable to afford private psychiatric care.

FOLLOW-UP CARE

The discharged hospital patient is usually seen within one month after he leaves, although an appointment can be arranged the week after discharge if this is recommended by the hospital staff. The psychiatrist and the social worker discuss each patient, and the psychiatrist prescribes medication. Since follow-up care involves primarily an evaluation of the patient's ability to function socially, the majority of discharged patients are seen only by the social worker except for brief contact with the psychiatrist for medication. The psychiatrist does see discharged patients if a psychiatric evaluation is needed, if there is a question about returning the patient to the hospital, or if the social worker asks him to see the patient. Family-care patients are handled in much the same manner, with the social worker being responsible for supervision of the family-care homes. The social worker sees relatives regularly if it appears that this is necessary for the patient to make the best possible adjustment outside of the hospital.

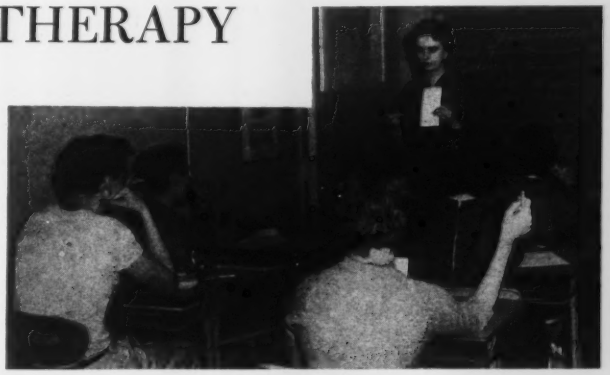
Routinely, the conditionally discharged patient returns to the clinic once a month until he receives his final discharge, usually one year after he leaves the hospital. The authors do not feel that adequate follow-up care can be provided when the patient is seen only once every three months. Because of the relatively flexible administration of the outpatient clinic, patients feel free to contact the clinic at any time. If the patient needs to be seen weekly for a month or two, this can be arranged. If he does not need to be seen as often as once a month, he is usually discharged from the clinic. After a patient is discharged from the clinic he may come back if he notices an exacerbation of the symptoms that led to his hospitalization. Often it is possible to prevent return to the hospital by seeing the patient for three or four interviews. The patient who enters the hospital

volun arily through the outpatient clinic is encouraged to ret rn for at least one follow-up interview after being disch rged from the hospital. A decision as to further outpa ient treatment is made at the time of this interview.

I is important that the same staff member see the patie t during the entire follow-up care period. It is also impor ant that he be treated with dignity as a responsible adult. Clinic arrangements are made directly with the patie t whenever possible, since he is held responsible for his own treatment. In supportive therapy, reality testing and adult behavior are stressed. The authors feel that if the patient is expected to act "well" and to perform up to his capacity for functioning as an adult, he will respond well to outpatient treatment.

The outpatient clinic at the Galesburg State Research Hospital functions both as a hospital screening center and as an after-discharge follow-up clinic. The role of the family physician in the treatment of the psychiatric patient is vital; and with this type of clinic, effective liaison can be established and maintained between the state hospital and the family physician. The authors feel that such a clinic tends to help the state hospital provide comprehensive community-oriented treatment for the seriously ill psychiatric patient. •

PSYCHOEDUCATIONAL THERAPY



THE TERM "PSYCHOEDUCATIONAL Therapy" is a projection and an extension of the more familiar Educational Therapy. It implies not merely the imparting of formal education, but an equal concern with the emotions and the emotional dynamics of the persons under treatment. Specifically, it utilizes insights gained through the hospital treatment program to provide the patient with a situation in which he learns and practices new skills for living, and experiments in mutual relationships with other people.

At the Saint Louis State Hospital this function is the concern of the Patient Education department, which is a branch of the Activities Therapies division. Patient education is organized as a multiphased program which is available to the total hospital population.

Adult evening classes are conducted during late afternoon and evening hours throughout the week. The curriculum is based upon patients' interest as reported by regularly conducted surveys. Patient participation is purely voluntary in nature. Considerable community interest is witnessed by the fact that teachers in this program are hospital volunteers who hold regular teaching positions in the community and willingly devote their time to the instruction of interested patients.

Daily sessions, usually held during the morning hours, have been established primarily for the adolescent patient. The curriculum is a general one consisting of basic studies on both the elementary and secondary levels of academic achievement. Teachers in the adolescent programs are salaried hospital staff teachers. With increased admissions of adolescent patients, this phase of the education program has gained much momentum and is evolving into a great proving ground for effective communication in an intensive multitherapeutic approach to mental illness. Here the role of psychoeducational therapy is paramount, since many youngsters are certain to return to a community-school situation upon release from the hospital.

Both the adult and the adolescent programs are conducted on a small-group basis. At present the maximum number of patients in any one group is eight.

Another phase of patient educational service is the tutorial phase, which includes those patients who can benefit from psychoeducational therapy but because of severely deviant behavior or severely impaired learning abilities require a flexible, highly individualized approach.

Supplementary services which are allied to this psychoeducative process include evaluation and accreditation by local schools and consultation with state agencies.

The functions of psychoeducational therapy in a multitreatment program are: 1) to contribute to the environmental structure of the hospital; 2) to provide pertinent information useful to the evaluation and diagnosis of the patient; 3) to assist the patient in his rehabilitation and return to the community by equipping him with certain skills related to the responsibilities of living.

A further implication of the role of psychoeducational therapy goes beyond the hospital setting and into the community-at-large. This is the use of psychoeducational techniques in the classrooms of our community schools as one of the preventive and revealing tools for dealing with emotional disturbances in young people. Although many state governments have no legislation in force making provision for the education of emotionally disturbed or maladjusted youngsters, it is my strong belief that social obligations will some day demand that provision be made for these young people. What we now accomplish in the hospital setting will be invaluable as a resource in expediting this much needed community program.

JEROME DAVIS
Director of Patient Education

Dr. Whatsisname Speaks of Many Things

The following is an exclusive interview with our own Dr. Whatsisname, who this month celebrates his fifth straight year as a columnist for MENTAL HOSPITALS. His articles and catchy sayings have been reprinted in a number of publications and he recently starred in a motion picture entitled "Appraisal of Competency," released late last year (see page 37). Through the magic of the printed word we are presenting this interview as it actually happened. Any similarity between the following and what may have appeared in his column is purely uncoincidental.

REPORTER: How do you do, Dr. Whatsisname. I'm Eugene Youtz of MENTAL HOSPITALS magazine. Just call me Gene.

DR. W: *Sir, the unilateral use of the first name, no matter how tenderly uttered, is a symbol of inferiority status. The last name without the "Mr." is an even curter badge of inferiority. To address Eugene Youtz as "Gene" is patronizing. To call you Youtz is insulting. To call you Mr. Youtz is to enhance dignity and salute individuality. Why should we do less?*

REP: Well, ah . . . yes. Then just call me mister. Strange of me to say that—that was the title of the first article you published in MENTAL HOSPITALS five years ago. Tell me Doctor, I mean Dr. Whatsisname, to what do you attribute your . . . uh . . . uh . . . gift of gab?

DR. W: *The phrase you were groping for is "verbal ammunition."*

REP: Ah yes, the title of another of your many articles. Do you think this "verbal ammunition," as you call it, makes a doctor sound more professional?

DR. W: *No! The psychiatric lexicon is indeed loaded with words which make the ordinary fellow blush or bristle. To say that a thought is unconscious is, to innocent ears, an insult. The word "ego" may be a special noun to you but to the uneducated it means conceit.*

REP: But . . .

DR. W: *And many of the staff doctors are reported to be wallowing in the words thus offered. Medical charts are showing the effects of stringing words together like beads. One patient is written up as pensive, sad, and woebegone. Another is characterized as sated, grim, and grief-stricken. Purple prose is beginning to burgeon in state hospitals.*

REP: But Dr. Whatsisname, in your article called, "The Pen is Mightier," you say, and I quote, "The flow of paper will never abate. Records are larger and holier than ever before . . . in the modern hospital, the pen is mightier than the scalpel. He who controls the paper work is in the driver's seat." Isn't this sort of contradictory?

DR. W: *Not at all, Mr. Youtz,—It's All Relative—as I said in June of 1958. Regardless of how you describe them, there are no uninteresting cases.*

REP: I see Doctor. Now I wonder if we might get your views on the climate of the hospital in general.

DR. W: *The general hospital is a hotel for sick people, and what with early ambulation and wonder drugs, the average patient doesn't stay in that hotel long enough to be much affected by its climate.*

REP: No . . . what I meant was, what do you think about the general state of the state mental hospital? I mean, the mental state of the state mental hospital. I mean . . .

DR. W: *What you apparently mean, is—When Is a Hospital Not a Hospital—precisely the topic of another of my articles. It was a proud day when we changed the name from asylum to hospital. Since then—hospitals—the other kind—have sharpened their focus. By now the public has a model of a hospital, and we don't quite fit it.*

REP: But Doctor, you once wrote an entire piece called —Why Not An Asylum?—in which you said . . .

DR. W: *In which I said, "The word 'asylum' is now either obsolete or obscene. But let's face it—some patients do need quiet and protection, at least for a while, from the world that has been too much for them.*

Purple prose is begining to burgeon in state hospitals.

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REP: Yes, I can see that. I suppose this is a problem of doing the right thing at the right time. Requires a great deal of dedication, I suppose.

DR. W: *We toss around that word "dedication," but no one seems to have listed the ingredients. We know what dedication is not. A dedicated person need not necessarily be intelligent, efficient, or competent. Nor does dedication imply intransigence. So long as he moves toward the goal, the dedicated person is willing to compromise on means.*

REP: But you once said that compromise often causes only indecision and division of responsibility, and the line must be drawn somewhere.

DR. W: *Yes, and every man must draw that line for himself, but he who draws it so close that he never yields is not dedicated; he is pigheaded. And the one who draws the line so far away that he is always quick to compromise is not dedicated either; he is an opportunist.*

REP: What a wonderful way to put it. I'll just jot that down . . . I hope you don't mind my taking notes . . .

DR. W: *Somebody ought to write a doctoral thesis on note-taking. Either you take notes—or you just listen, grunt, and remember. Furthermore you can't write down everything. So you had better train yourself to remember. Memory can be trained. An interview is like an operatic aria. It means more to get the music than the words.*

REP: You're absolutely right, and I apologize. It is a little difficult writing on my lap. I had the idea before I came in that you would be sitting behind your desk engrossed in a mass of paperwork, and that I would be able to use your desk to write on. And instead, here we are just sitting in two comfortable chairs in the middle of the room. Is that your desk over there in the corner?

DR. W: *Yes. We are—Breaking Down the Desk Barrier.*

REP.: We are?

DR. W: *Why shouldn't we be seated as if in a living room or library, as if at a fireside? The magic cord between us is strung so much more easily when the chairs are in this friendly posture. By this living room arrangement we can communicate, without words, the sentiment that we "share an experience together."*

REP: Magic cord . . . fireside . . . operatic arias . . . sounds just like something from a romantic adventure story.

DR. W: *Romanticism is almost dead, but not quite. There is still the psychiatrist.*

REP.: Somehow I never thought of psychiatrists as being romantic.

DR. W: *The psychiatrist and only the psychiatrist remains as the true spokesman for the romantic. Let us hope that it will be a long time before he succumbs to group therapy without individual interviews, to mechanical laboratory work-ups, electronically interpreted tests, and general automation. We psychiatrists should be kept alive (if for no other reason) as the last living specimens of the true romantic. Magic lies in the title and tradition of the physician, the healer, the source of solace. With such magic in our hands it is a pity that we do not wield it more often or more steadily.*

REP: If I may say so, Dr. Whatsisname, you managed to wield this magic in most of your articles over the last five years. Your ability to look at every side of a situation has probably made you one of the most well-known men in psychiatry. I wonder if you could sum up for our readers what has been your secret of success.

DR. W: *It's perfectly simple—one has to know when to keep his mouth shut, even if he has to sink his teeth into problems—which is tough going, especially when nothing may stick in his crop. His skull must be firmly planted on his shoulders, for he must never lose his head; and while he should not have to bend his neck, he must be willing to stick it out from time to time, meanwhile keeping the area beneath his mouth well-armored so he can take it on the chin.*

REP: Well, Doctor, on behalf of the magazine and its readers, may I say that this has been a most interesting and informative discussion. Thank you for letting us visit with you.

DR. W: *Not at all. Nothing like having some inquisitive students of any age to ask questions. Its the best brain prod known to man . . . provides an intellectual ferment that will keep everybody's wits sharp. Pardon the mixed metaphor—maybe ferments don't sharpen things, but at least they keep the intellectual pot bubbling, and that's all to the good.*

Why shouldn't we be seated as if in a living room?

We psychiatrists should be kept alive as the last living specimens of the true romantic.

"Magic lies in the title and tradition of the physician . . . the source of solace."

One has to know when to keep his mouth shut . . . never lose his head.

Nothing like inquisitive students to ask questions . . . its the best brain prod known to man

THE CHANGING SCENE:

The Volunteer as an Index

By WINFRED OVERHOLSER, M.D. (1947-48)
Superintendent
St. Elizabeths Hospital
Washington, D. C.

THE ROLE OF THE RED CROSS GRAY LADIES was familiar in military and Veterans Administration hospitals during both World Wars. Since World War II particularly, the movement has spread to civilian hospitals, so that many of them have well-organized and extensive volunteer programs. The programs are significant manifestations of the oneness of the hospital with the community—a recognition that the hospital is dependent on the public's cooperation if it is to do the best possible for its patients. Indeed, the growing use of volunteers may be considered a concrete index of changing attitudes toward the mental hospital.

It is undoubtedly true that a psychiatric revolution is currently under way. There have been extraordinarily rapid developments in the concepts and methods of treatment of mental illness since World War II, when heightened pressures caused many members of the armed forces to suffer brief episodes of psychiatric illness. Their subsequent and fairly prompt recovery emphasized to previously skeptical medical officers that there really was "something to" psychiatry after all.

Community attitudes reflected a similar broadening: the public, knowing of these transitory war disturbances, came to realize that under stress, young men—apparently good risks otherwise—might undergo temporary breakdowns. The public learned that mental illness is not an experience entirely apart from the general experiences of life, but one that is treatable and far from hopeless in prognosis. Thus, the medical profession and the community began to realize that the former physical and spiritual isolation of the mental hospital was undesirable, and that there should be closer cooperation between the hospital and the rest of society.

To be sure, there had been new approaches to treatment before World II, notably insulin coma and metrazol, the latter closely followed by ECT. These treatments excited enthusiasm at the time (enthusiasm which has somewhat subsided) and emphasized to the laity that mental disease is treatable. Group psychotherapy, used to some extent since Dr. Joseph H. Pratt's work in Boston, was given impetus during the war, partly because of the shortage of psychiatrists. Its development revealed desirable features of this form of psychotherapy in addition to the fact that one physician can serve a number of patients simultaneously. Psychodrama, as a specialized form of group psychotherapy, had been introduced by Dr. Jacob L. Moreno before World War II.

Since the war, the English example of open wards has attracted attention in this country, and many hospitals are following the principle to a greater or lesser extent. With the development of this policy has come a more tolerant community attitude, particularly in areas immediately surrounding the hospitals. The growing use of day and night hospitals has become a means of gaining the active cooperation of the family.

Rehabilitative aspects of psychiatry were given impetus by the broadening of the Federal Law concerning rehabilitation; originally, rehabilitation was conceived as an approach to the physically handicapped, but during the war the government recognized that it owed an equal obligation to persons handicapped by mental illness. The expanding functions of social service and rehabilitation activities, and the concept of institutions as therapeutic communities, have done much to bring the hospital and its patients closer to the community.

The Congress has expressed its great interest in these matters by granting generous appropriations to the National Institute of Mental Health and by supporting the Joint Commission on Mental Illness and Health. State legislatures, too, have shown their interest and reflected their constituents' growing concern by increasing appropriations for hospital maintenance and the development of community facilities.

One of the great advances in drug therapy was the development of the so-called ataractics in the middle of the last decade. These drugs received much acclaim and were hailed as performing miracles. They have indeed shown themselves to be valuable, particularly in institutional care of the mentally ill, but they alone would not have produced the increasing number of releases

from hospitals had it not been for the changing attitudes of hospital administrators and of the community. These new attitudes and practices constitute a modernization of the "moral treatment" which was preached by Pinel over a century and a half ago.

As public acceptance of psychiatric concepts has increased, we have seen a growing use of volunteers in the hospital operation. This development has dual significance: it is the result of a change of community attitudes, and at the same time, does much to encourage them.

THE PERSONAL TOUCH

Let us consider some of the values of the volunteer to the patient. No matter how kind the hospital personnel may be, or how solicitous of the patient's welfare, its members are employed professionals, gaining their livelihood by serving the patient who, to some extent at least, views them as detached and impersonal in their attentions. Again, the hospital may be physically isolated, despite modern advances in transportation. In any event, the patient who is plucked from his home surroundings and finds himself in a hospital is bound to feel somewhat isolated and strange. These feelings are reduced by the presence of the volunteer, who derives no financial benefit from her work and is not beholden to the institution, but is there solely because she is interested in the patient. She is, so to speak, a breath from the outside world, and a welcome one—a link with the society from which the patient is temporarily removed. This in itself is a great reassurance. It demonstrates to the patient that the volunteer, as representing the community, is not afraid of him or of the hospital. The volunteer also represents reassurance to the hospital staff that the community is interested in the work it is doing.

If a volunteer program is to be successful, however, the hospital must fulfill certain obligations. First of all, there should be a preliminary screening of the persons (usually women) who seek volunteer work. Some are, perhaps, more interested in solving their own problems than in being helpful to the institution and to the patients; therefore study of their motivations is in order. Furthermore, the volunteer should be oriented and trained. She should know something about proper attitudes toward the mentally ill; proper relations between volunteers, patients, and staff; the organization of the hospital; and where she fits into it. The necessity of keeping confidences and avoiding gossip with friends and neighbors about what she learns in her professional capacity is a lesson of great importance for the volunteer to learn. Many volunteers have various special skills that should be utilized as much as possible in their hospital work. However, these skills should be utilized over and above, and not as replacements for regular hospital activities.

The volunteer is not a substitute employee. She has a very special function of her own. There must, of course, be some coordination and general supervision by the staff, and an understanding by the volunteer of the necessity for such coordination in maintaining orderly administration of the hospital. At the same time, there needs to be an understanding on the part of the institution's staff of what the volunteer is doing and can do. Every effort should be made to incorporate the volunteer's work into the other activities of the hospital—not to have her operate in a separate orbit.

What sort of services may one expect from the volunteer? Activities in which the volunteer may be useful and of value to the patient are legion. Only a few examples need to be cited here. A very common use is that of receptionist; this furnishes a useful adjunctive service in welcoming visitors and making them feel at home. Filing of records is another type of activity, although it does not bring the volunteer into particularly close touch with patients. Library work— distributing books in wards, conducting classes, reviewing books, etc.—is a valuable service, as are recreation and sports. Entertainments may be sponsored by outside volunteer groups or developed by the patients. Volunteers often give lectures on current events and history. Some teach classes in art, music, dance, languages, typing, or stenography. Others organize stamp and chess clubs, or domestic science groups among the patients. One possible activity, often overlooked, is reading to blind patients; this is deeply appreciated by sightless patients who are likely to feel—and perhaps really are—very much neglected.

All of these functions and many others which the volunteer can perform support the basic principle of hospital care, namely, the resocialization of the patient. The more these activities are desired by the administration of the hospital, the better they will work and the greater will be their value to the patients.

SOURCE OF INFORMATION

We think of the volunteer, and very properly, as primarily interested in the care and activities of the patients. There are, however, other aspects of volunteer work which should not be overlooked. The volunteer, after all, usually takes an active part in community affairs, in women's clubs, bridge club, and church. Through this participation she comes in contact with friends who almost inevitably will be interested in, and even curious about, the hospital, and what the volunteer is doing there. She can answer her friends' questions from firsthand knowledge. She has an advantage in being known by her friends to have no financial interest in the hospital; she knows about it as a citizen rather than as an employee. What she tells her friends will thus be accepted as being uncolored by self-interest, whereas this cannot be said for the words of one who is on the hospital's payroll.

The volunteer should know from her orientation course not only the best of the hospital and what it is doing for the patients; she should know the worst as well, so that she may emphasize to her friends the hospital's needs, as well as its assets and accomplishments. She is in a position to encourage her friends to make gifts to the hospital for the benefit of the patients, or to provide entertainment.

There are, unfortunately, too many misconceptions about the nature of mental disorder and the work of the

mental hospital. The volunteer is in a singularly strategic position to correct some of her friends' misconceptions. She can encourage them, too, to join their local mental health association and perhaps, to take up volunteer work themselves. This public relations aspect of the volunteer's work is one we cannot afford to overlook. In more than one state, citizens' organizations including volunteers and their friends have operated to the great advantage of mental hospitals by bringing the urgent need for larger appropriation to the attention of governors and legislators.

TWO-WAY STREET

So far, we have spoken of the volunteer's value to the patient as a friend and aide, and to the hospital as a medium of good public relations. But her activity is not solely one of giving or informing. It has, in addition, certain values for the volunteer herself. There are many personal satisfactions that provide continuing motivation for the devoted service of these women.

The knowledge the volunteer gains in the hospital may be useful in advising friends about where to turn for help if mental illness occurs in their families. She may also acquire insight into her own idiosyncrasies and those of her friends. She learns much about the need for good humor, sympathy, and self-assurance. She witnesses the devotion of the nurses and the ward personnel who are caring for the patients, and learns from close contact the meaning of human suffering. She soon realizes that such things as chains, padded cells, and shrieking inmates are things of a long bygone era; that they do not exist today; that, on the contrary, there are many parallels between the mental hospital and the community, and that the patients are not of a different order of creation, but are much like herself and her friends.

Although, in these sophisticated times, there are those who deny the existence of altruism, I am convinced that there is much evidence that it still persists; that many persons have a willingness to help others and a feeling of public obligation and of generosity. We all honor Albert Schweitzer as the embodiment of this enduring spirit of altruism.

It should be heartening to psychiatrists to remember that the earliest hospital facilities for the mentally ill in this country were not publicly organized and operated. Long before public mental hospitals existed here we had, for example, the New York Hospital, the Pennsylvania Hospital, the Hartford Retreat, and the McLean Hospital (a part then, as now, of the Massachusetts General Hospital). All of these institutions were organized and supported by philanthropic men and women who felt obliged to do something for the less fortunate. Their philanthropy is to their everlasting credit, and to the credit of their spiritual partners or successors—Dorothea Lynde Dix, Clara Barton, Samuel Gridley Howe, and still more recently, such munificently generous persons as Henry Ford, Andrew Carnegie, and the Rockefellers.

We now have the Community Chest, an example of altruism on a wide scale. In our country, love for humanity is still alive in spite of the too-prevalent cry of "Let Washington do it." The American volunteer exemplifies the truth of Freud's discovery that to experience love, we must give it. She derives a truly spiritual value and abiding satisfaction in following the Golden Rule and giving of herself to others.

In fostering closer relations between the hospital and the community, and in developing a truly social psychiatry in the evolution of the care of the mentally ill and in their rehabilitation, the volunteer will continue to play a significant role. She is in every way an exemplar of this closer relationship.

Former Surgeon General Joins A. P. A. Staff

Rear Admiral Bartholomew W. Hogan assumed the duties of Assistant Medical Director of the American Psychiatric Association on March 1, following his retirement as 22nd Surgeon General of the U. S. Navy. A native of Massachusetts, Admiral Hogan received his M.D. from Tufts in 1925 and was appointed a Lieutenant in the Navy Medical Corps in June of that year. He achieved the rank of Rear Admiral in 1952 and became Surgeon General in 1955.

Admiral Hogan is a former Fellow and now an Honorary Fellow of A.P.A. He is also a Fellow of A.M.A. and of A.C.P., a diplomate of the American Board of Psychiatry and Neurology, a trustee of the American Hospital Association, and a member of the A.M.A. House of Delegates. He holds honorary degrees from five universities and is an associate professor of psychiatry at Georgetown University.

The staff of MENTAL HOSPITALS is pleased to join with the Medical Director and the rest of the staff of the Central Office in welcoming Doctor Hogan aboard.

A "TAX BREAK" FOR MENTAL HOSPITAL EMPLOYEES

By CHARLES H. JONES, M.D.,
Superintendent
Butler Health Center, Providence, Rhode Island

THIS MONTH ends the first year of an unusual savings-retirement plan in operation at Northern State Hospital,* Sedro Woolley, Washington, by which employees can defer paying Federal income tax on as much as 20 per cent of their annual incomes. This is probably the first state mental hospital to utilize an innovation in the federal income tax structure which allows employees of certain nonprofit, welfare organizations to set aside portions of their incomes in annuities, etc., without paying taxes on them until the employees either change jobs retire, or their annuities mature.

Under the provisions of the Technical Amendments Act of 1958 (The Mills Bill), retirement planning for employees of nonprofit organizations covered under Section 501 (C) (3) of the Internal Revenue Code has been facilitated as follows: Section 403 (B), one of the new amendments, provides that premiums paid by tax-exempt organizations for an employee's annuity, if the employee has nonforfeitable rights to it, are taxed to him only if they exceed a liberal exclusion allowance of approximately 20 per cent of his salary.

The legal foundation for the program is entirely sound. The Mills Bill merely authorizes tax treatment for employees of charitable institutions similar to that long accorded to employees of corporations. It does not foster tax schemes or tax evasion, but encourages individual savings and retirement planning by allowing more favorable tax treatment on an optional basis. Its major advantages to a state mental hospital are its attractions to key personnel to remain in service, and its use as a sales point for recruiting well-trained consultants.

Starting the program at Northern was not easy. The possibility of such a plan was first discovered in an article[1] on the Mills Bill which was published in *Medical Economics*, 1958. However, subsequent inquiries to several insurance brokers in late 1958 were fruitless, indicating that the law was too new and that no applicable annuity policy could be found. Letters sent to the Department of Institutions in Olympia, Washington, suggesting that monies paid by state employees to the Washington Retirement Board System might be covered by the Mills Bill, were equally nonproductive.

Finally, in late 1959, after persistent inquiries and false leads, Mr. Julius E. McLeod, an insurance broker in Seattle, formulated a proposal based on an existing annuity plan offered by a large national insurance company. With the author's collaboration, the administrative details were then worked out so that the plan could be put into effect, consistent with the laws of Washington.

FIRST STEP—TAX EXEMPTION

What should have been the first step was overlooked until late in the organization of the plan, when Mr. McLeod was perplexed to learn from an Internal Revenue Department Office that Northern State Hospital was not listed as a 501 (C) (3) tax-exempt organization. The department does not automatically list all eligible organizations; ratings are given pursuant to an application. However, following the hospital's formal application, notification was received that the institution did qualify as a tax-exempt, charitable organization.

Investigation showed that the 20 per cent maximum allowance for deferment applied to annuities purchased in the form of a raise over existing salaries, but such was *not* to be the case for the plan contemplated for Northern. Rather, the maximum percentage deferable from *current* salaries, at the option of employees, proved to be 16 2/3 per cent or 20 per cent of the remaining 83 1/3 per cent of the existing salaries. In short, a maximum of 1/6 of established state salaries could be deferred under the plan during the first year of employment.

The total formula is that *the amount of salary which can be deferred must not exceed 20 per cent of the actually received salary multiplied by the number of years of employment by the single-tax exempt agency, minus the amount of compensation deferred previously during that period.*

*The author was formerly superintendent of Northern State Hospital.

[1] "Help Yourself to a Tax-sheltered Annuity" Med. Econ. (Sept. 15, 1958) p. 67.

The length-of-service factor in the formula led employees who were considering the plan to work out all sorts of individual applications. The following is only one of a great number of possibilities.

Mr. K., 47, is currently receiving $10,000 a year as business manager of a state mental hospital. He has been working for the hospital for 10 years and would like to set his tentative retirement date at age 62. For personal reasons he would like to take advantage of the maximum deduction allowed under the Mills Bill in the form of annuity contracts. Had he been able to participate from the beginning of his employment, under the previously mentioned formula, he would have been able to defer $41,666 in 25 years. But, in spreading this amount of deferment over the remaining 15 years of his employment, the algebraic effect of a yearly deduction of 1/5 of the amount from $10,000 so reduces his taxable yearly salary that the allowable 20 per cent of the remaining sum is too small to support a total deferment of $41,000. Thus, to solve his particular problem, the following simple formula, which applies to employees who want to pick up credits for past years, is used.

$$P = \frac{1000Y}{Y + 5N}$$

P equals the maximum sum divertible per $1,000 of present annual salary.
Y equals total number of years of service.
N equals number of annual premium contributions (or years left before retirement).

Therefore, $2,500 would be the maximum divertible from Mr. K.'s salary of $10,000 a year, without tax liability. According to Table I, Mr. K. would defer $2,500 a year free from income tax and pay taxes on only $7,500. *Due to prior service,* he can defer a maximum of 25 per cent of his current salary rather than the 16 2/3 per cent allowed a new employee.

TABLE 1

Age	*Years of Service*	*Gross Allowance*	*Past Premiums*	*Net Exclusion Allowance*
47	11	$16,500 (20% of $7,500 x 11)	None	$16,500
48	12	18,000	$2,500	15,500
49	13	19,500	5,000	14,500
50	14	21,000	7,500	13,500
51	15	22,500	10,000	12,500
52	16	24,500	12,500	11,500
53	17	25,500	15,000	10,500
54	18	27,000	17,500	9.500
55	19	28,500	20,000	8,500
56	20	30,000	22,500	7,500
57	21	31,500	25,000	6,500
58	22	33,000	27,500	5,500
59	23	34,500	30,000	4,500
60	24	36,000	32,500	3,500
61	25	37,500	35,000	2,500

After the program was presented to about 60 department heads and professional employees, many were quick to see its unique features and 28 signed up for the plan. Not only is the value of their money compounded at a rate of 3 per cent annually on a currently tax-free basis, but the compounding also accrues to their benefit on the money they would otherwise pay in tax. In other words, each employee gets the compound interest value of the tax money for the life of the plan at no cost. Moreover, the taxes on their money will ultimately fall due at a time when the tax rate will most probably be reduced, and when more personal deductions might be applied.

TAX-FREE BENEFITS

The plan also allows numerous annuity options to be exercised at the time of retirement according to the best method of payment fitting the circumstances. If the selected option contains a death benefit, the first $5,000 is tax free to the employee's beneficiary. Likewise, if the employee dies while still working, his beneficiary receives the first $5,000 of the death benefit tax free. Furthermore, none of the death benefits under the plan are subject to Federal estate tax.

One question frequently asked is: What will happen if an employee leaves the hospital before his retirement? The answer is that the paid up annuities plus the interest will be issued. The employee can then cash in the annuity or elect options on his retirement date or earlier, paying portions of the money as deferred income tax.

The deferred tax plan is particularly attractive to many part-time and consulting physicians who are in private medical practice and in high tax brackets. The mythical example shown below shows that part-time or consultant positions at mental hospitals might be more financially attractive than they have been during the past.

PART-TIME APPLICATIONS

Dr. R., a board-certified internist, is in private practice in a city close to a state mental hospital, and holds a faculty appointment as an assistant clinical professor of internal medicine at a local medical school. Although Dr. R. particularly enjoys teaching, he is on service at the teaching hospital for only three months of the year. Upon hearing that the salary of a newly established consulting post at the nearby state hospital would be covered by the institution's tax deferment plan, he quickly accepted the appointment. It was explained to Dr. R. that the established state salary for a certified internist is $18,000 a year. Since he agreed to a schedule of two mornings a week, his pay would be 1/5 of the established salary.

The deferred compensation plan in effect at the hospital would allow him to receive $3,000 a year in cash and $600 in annuity contracts. While this was a very effective arrangement for him, considering his tax bracket, he found that a consultant who had many years of previous service would be in an even more enviable situation, with a maximum divertible from an established

state salary, without exceeding his exclusion allowance, computed by the following formula.

$$P = \frac{1000Y}{Y + 5FN}$$

F equals the fraction of full-time service the employee renders during the year.

The adoption of a Mills Bill plan would not have been possible at Northern State Hospital were it not for a state law which allows payroll deductions from Washington State employees for certain purposes including insurance annuities. Administratively, all that is required is for a state agency to submit signed requests by 25 or more employees for deductions for any one authorized purpose. The lack of such a law in other states might bar the utilization of the Mills Bill which specifically requires that the annuities be purchased by the employer for the employee at his request. In such states remedial legislation may be in order since the Mills Bill option might be regarded as a distinct fringe benefit, although in actual practice it costs the state nothing.

TABLE 2

Deferred tax plan of Dr. R.

Year	*Gross Allowance*	*Past Premiums*	*Net Exclusion Allowance*
1959	$ 600 (20% of $ 3,000 x 1)	None	$600
1960	$ 1,200 (20% of $ 6,000 x 1)	$ 600	$600
1961	$ 1,800 (20% of $ 9,000 x 1)	$1,200	$600
1962	$ 2,400 (20% of $12,000 x 1)	$1,800	$600
1963	$ 3,000 (20% of $15,000 x 1) Full annual salary	$2,400	$600

Foot Care for Mental Patients

By JAMES A. CONFORTI, D.S.C.
Hawthornden State Hospital, Macedonia, Ohio

THE MANY CHRONIC AND TRANSITORY foot problems which occur in any segment of the population often create a need for special consideration. Where an institutional population of more than several hundred people exists, the variety of foot pathologies which may present themselves can become burdensome to the medical staff, so that only limited attention can be given to these various foot ills.

This situation is readily understandable. The fibrillating patient requires greater medical attention than the patient who suffers from an acute arch-problem or bursitis under a heel, but the latter conditions are often just as incapacitating to the patient, preventing him from performing normal or routine activities. In the mental patient, the presence of physical pain, and particularly the discomfort of a chronic foot problem, further diminishes his ability to think for himself or to concentrate, and lessens the effectiveness of other therapeutic regimens.

In the experience of the chiropody department of Hawthornden State Hospital, the one most bothersome foot condition which causes concern to the nursing and psychiatric-aide staffs is the hyperkeratotic (extremely thick) toenail. The chiropodist-podiatrists cannot keep all the nails of all the patients trimmed properly, but they can assume the care of all the thick and deformed nails, while the aides provide ordinary care for toenails. Nurses, aides, or attendants should not be expected or required to reduce thick or deformed nails, particularly when the patient is diabetic or suffering from peripheral vascular disease. The chiropodist-podiatrist is licensed in all states and territories, and is qualified to assume this responsibility.

The chiropody department possesses a wide variety of instruments which have been developed especially for certain needs. Various types of nail nippers, splitters, nail curettes, and scalpels are necessary to provide the best type of care for any specific foot condition. The chronically ingrown or incurvated nail, for instance, where surgical correction may be impractical because of circulatory or other systemic problems, usually requires professional treatment.

Among the many other conditions treated by foot doctors are abrasions, blisters, corns, calluses, fungus conditions, ulcers, dermatoses of various origins, joint problems such as bunions and hammer toes, arch conditions, bursitis, neuritis, tendinitis, and foot injuries.

The provision of more extensive care of extreme cases depends upon the general hospital facilities available in the chiropody department. For example, surgical correction of toe deformities and bunions, neurectomies,

and other types of foot surgery can be performed within the jurisdiction of the department of surgery. Physical therapy may be applied in the chiropody department or prescribed for the physical therapy department when such exists in a mental hospital.

ESTABLISHING A PROGRAM

A basic program of foot care in mental hospitals should include the following responsibilities: (1) Initial foot examinations for all new admissions, plus follow-up treatment; (2) Routine foot examinations and follow-up care for all patients, including ward examinations for non-ambulatory cases; (3) Management of chronic foot pathology on a regular treatment basis and/or as needed; (4) Treatment of transitory pathology and emergencies; and (5) Consultation with members of the medical staff and other departments regarding specific foot problems.

It is impossible for a chiropody department to function without the full cooperation of the medical staff, and it is the chiropody department's responsibility to cooperate with the members of the medical staff so that maximum benefit for the patient can be derived from the foot-care service. With the increased use of all types of medication in our mental institutions, it is imperative that the chiropodist-podiatrist have complete familiarity with the drug regimen upon which each patient has been placed, and consult with the ward doctor before prescribing any internal medication for a patient.

On occasion, some schizophrenic patients may exhibit transferral symptoms, complaining of painful feet but showing no signs of pathology. Podiatric evaluation of such symptoms may assist the psychiatrist in making a more valid diagnosis of the patient's over-all condition.

SAMPLE SURVEY

The number of patients requiring foot treatment varies from time to time. A random-sample survey was taken in the spring of 1959, when the Hawthornden State Hospital patient population was approximately 1800, with a ratio of two female patients to each male patient. With definitions of "chronic foot pathology," "transitory foot pathology," and "no foot pathology" clearly circumscribed, the actual result of a sampling of one hundred males and one hundred females was as follows:

Sex	*Chronic F.P.*	*Transitory F.P.*	*No F.P.*
Males	44	25	31
Females	63	12	25
Totals	107	37	56

It is obvious from the above figures alone that the total number of patients exhibiting signs of foot pathology at any given time could be a substantial portion of the patient population. Application of the formula for validating a statistical survey so that results would fall within a 95 per cent confidence level indicates that in any similar statistical universe the ranges of chronic and transitory foot problems are of such magnitude as to warrant serious medical consideration.

CLOTHES TO FIT THE PATIENT AND THE SITUATION

By LEONARD GOODMAN
Account Executive, Victor Kramer Co. Inc.
Laundry Management Consultants, New York City

DO CLOTHES MAKE THE MAN? While of course it's possible to overstate the case—to suggest, say, that by donning Babe Ruth's old uniform your high-school Latin teacher could hit 60 home runs—nevertheless, the simple psychology behind the saying is operative in all of us every day. If we're going out to dinner or to the theater, we dress up in order to give ourselves a sense of visual appropriateness. This in turn helps to adjust our attitude to the occasion and thus, by bringing both our appearance and outlook into harmony with the event, undoubtedly enhances our enjoyment. Similarly, we would not wear a tuxedo or a cocktail dress for a tramp in the winter woods, but rather would dress in warm old clothes and boots, not only for the physical comfort they afford, but also for the emotional comfort of looking, and therefore feeling, "right" for the outing.

With certain obvious exceptions, there is no reason to suppose that mental patients are immune to the psychology of dress. Indeed, in some cases there is evidence of a special sensitivity to it. Our purpose in this article is to promote new, wider, and more constructive thinking about patient clothing in mental hospitals, without greatly increased clothing and laundry expenditures.

Mental hospitals formerly considered patient clothing as a low-budget item able to meet, but not exceed, the minimum requirements of common decency. If the institutional budget has only $15 a year for clothing purchases for each patient, then it is difficult to improve standards. Happily, this is changing. Already in Delaware, Maryland, New York, Ohio, South Carolina, Connecticut, New Jersey, Kentucky, and other forward-looking states, authorities are beginning to consider patient clothing at least in part a therapeutic issue. For example, there is today an accepted trend in favor of issuing pressed rather than rough-dry clothing. Wrinkled garments simply are not as pleasant to wear as smooth ones. Pressed clothes—like fresh bed linen, or interesting food, or a clean shave, or a new hairdo—provide the patient with a personal investment in the world around him, a link with the pleasant, tangible things of everyday living.

There's nothing far-fetched about this. The principle is the same as the one behind the issuing of dry socks to weary front-line soldiers. The morale boost obtained is far out of proportion to the modest comfort and cost of a pair of socks. Thus, with mental patients, it is not simply the fresh look and feel of pressed clothing that is so important, but the recognition implicit in its issue. Undeniably, pressing means some additional expense, but it should be considered more than just a laundry expense. Surely the rehabilitative effects of pressing—along with variety in color, style, and size of clothing—would indicate that part of the cost should properly be charged to therapy.

ECONOMY FACTORS

In any event, whatever extra expense is incurred can be kept to a minimum by judicious selection of style and fabrics. For instance, to keep pressing costs down, dresses chosen should be simple in construction so that they can be processed more easily. Also, while synthetic fabrics are a boon to the general public, they require special care in laundering. In mental hospitals, where patient-help is used in laundry operations, distinctions between fabrics are generally ignored, and synthetics are likely to be thrown into the high-temperature formulas along with cotton garments. This destroys synthetic fabrics and should discourage their use.

In men's clothing it is entirely possible to temper the traditional blue jeans and khaki work uniforms with trousers of colored denim or other material. Nor is any extra expense involved in varying the standard button-front shirt with slipovers that button at the neck, or with colorful knitted polo shirts which are not only neat and attractive, but require no ironing at all.

We all know that the question of dress and adornment is of particular importance to women. The fact that a woman happens to be a mental patient does not immunize her to this aspect of her personality. Quite the contrary, concern about her appearance might very well be one of the bridges to reality and self-respect, which the therapist can use more helpfully in treatment. This would appear to be especially true of convalescent women, who are able to construe increased appreciation of style, fabric, and color variety as symbolic of and contributive to their return to health.

With a little thought and ingenuity, many ways can be found to de-institutionalize the appearance of women's clothing: hemlines can be raised or lowered; belts may be added or removed; pockets can be sewn on, taken off, or repositioned; necklines and sleeves can be

altered; solid colors or prints can be used. Such variations add very little to the cost of the clothing, but a great deal to a patient's sense of personal identity.

In many cases, families and relatives supply patients with some or all of the garments needed. This practice should be encouraged, and hospitals should step up their efforts to acquire such privately owned clothing because it keeps the patient in closer contact with his family, provides him with individualized garments, and reduces the cost for the hospital. This is particularly important in training schools for mentally deficient children, who may require clothing changes several times daily.

Success depends, to a large extent, on close administrative controls within the hospital to prevent loss of this apparel. Relatives demand assurance that their dear ones will actually have the garments available when needed. Even so, it must be recognized that when the patient remains in the hospital for a prolonged stay, the tendency is for the family to provide fewer privately owned clothes as time goes on.

Efforts should be made to impress on relatives and other donors the importance of sending easily washable, colorfast clothing that needs no special laundering care. Apart from wool suits and overcoats, few garments should require dry cleaning. These suggestions are made with an eye toward avoiding well-meant but impractical donations. In many institutions there is little control over donated clothing and it becomes a case of "take what you can get."

Further, intelligent distribution of garments by patient-type will help get more mileage out of the clothing dollar. For senile or disturbed male patients—who are often completely unaware of their clothes, or who might try to destroy them—there is little point in providing any great variety. They are best outfitted in strong jeans or khakis. Working patients, while on the job, should be dressed in heavier clothing, with woolen underwear and sweaters, if the weather dictates. Here, too, practicality is the criterion, and, as in our walk in the woods mentioned earlier, fashion should wait on function.

EMOTIONAL SATISFACTIONS

When not on the job, many of the working patients, along with all convalescents, can appreciate, and should be issued, more distinctively styled garments in wider ranges of fabrics, colors, and sizes. It is with these patients that the suggestions offered in this article can be most effective. A convalescent patient understands the idea of individual, identified clothing and can keep track of his own wardrobe. He takes pride in his clothing, wants it to be different from that of his neighbors, and probably derives a definite emotional benefit from such individualized service. He is a step above the other patients, and on the road to possible recovery.

There are certain occasions in the lives of patients which call for special kinds of clothing—a dance, a party, a theatrical presentation, etc. We suggest obtaining special clothing to meet this need as it arises for the various groups of patients. This is the sort of

project that a hospital auxiliary or service group might be happy to endorse and promote, and donations of clothing for such a "costume wardrobe" would be relatively easy to solicit. Thus, at virtually no expense to the hospital, patients could be provided with the all-important "right" clothing for special occasions—occasions which, charged with extra meaning and involvement as they often are, might very well prompt additional therapeutic progress in the patient. On a small scale, the institution's own budget might supply fancier clothing for some occasions when it will be of greatest satisfaction to the patients.

THE APPAREL SHOP

In quite a few mental hospitals and schools for the deficient, "stores" have been established, where patients may select their own garments. These are stocked with various types of state-owned and donated clothing, both new and used. The "clothing shop" succeeds when there is close cooperation between staff and volunteers. It has considerable value for community education by enlisting the capable services of volunteers, both in the solicitation of donations and in the actual sales-service to patients.

The patient is "waited on" by a volunteer or employee saleslady who helps him pick out a wanted item, perhaps try it on, and make the "purchase." This provides the educable or trainable patient in schools for the deficient with experience in wardrobe selection and shopping, which is valuable for his ultimate return to community life. It is also a benefit to the oversize or "hard-to-fit" patient in obtaining the right garments for his personal needs.

Each article purchased is marked with the patient's name, just as all privately owned clothing is identified. In fact, the desirable practice is to mark state-owned clothing with patients' names and ward numbers to personalize clothing issuance, wherever possible. Progress in clothing distribution is moving from the unsatisfactory central pool, with its "small, medium, large," through the ward as a unit, to full identification of each garment by individual patient's name. The laundry receives and sends the clothing by ward designation, with individual sorting of clean garments performed within the ward.

CLOTHING DISTRIBUTION

A few years ago, an informal group of nurses, doctors, and business managers worked with the staff of the A.P.A. Mental Hospital Service to study the problems of clothing distribution. This group, headed by Mr. Alexis Tarumianz of Delaware, submitted a detailed report which offered an excellent guide for the handling of patients' clothing. Included among its valuable suggestions were such items as:

- A central facility for storing and issuance, located conveniently for access by all concerned, it should provide adequate storage space for all clothing items, whether fabricated, donated or purchased.
- It should contain a showroom where patients may select styles, and also a fitting room for alterations and repairs.
- One room should be reserved for mothproofing seasonal garments.
- The program should be under the direction of a qualified clothing supervisor. She would coordinate and supervise all clothing activities.
- Suggested Staffing—Clothing Distribution Section—1 employee to each 500 patients in residence, 1 patient-worker to each 800 p.i.r. Sewing Room—connected with it—1 employee to each 600 p.i.r., 1 patient-worker to each 300 p.i.r.

Now, it has hardly been our intention here to establish firm clothing standards for all institutions. Requirements and budgets vary greatly from one hospital to another, and the specifics must be determined locally. Although we have had a great deal of experience and success in helping to solve the problems in these areas on the local level, our purpose has been to suggest general techniques that can readily be adapted to any institution, for the purpose of increasing variety in patient clothing without significantly increasing costs. •

NEW PRODUCTS

Telescopic Window Washers

Housekeeping supervisors, faced with the task of keeping old and new buildings properly clean, have shown interest in telescopic window washers for making high window washing a faster and safer operation.

Using all six of the telescopic sections available with one model, the washer can be extended to 66 feet. Stretched to full length, and with brush and hose full of water, the washer tips the scales at a mere 20 pounds.

A special detergent, available from the manufacturer, cleans glass but will not etch paint, stain stone or brickwork, or harm shrubs. Wide flare brushes with nylon edges and polyurethane foam centers catch center edges and corners in one swipe.

Two men, each with a hose and brush, make the operation most efficient, one washing with the detergent, the second following with the rinse. The Tucker Manufacturing Company, Inc., of Cedar Rapids, Iowa, offers a wide variety of lengths in telescopic tubing, the superdetergent, and brushes cut to several window pane sizes.

Pipe Sealants

Hospital maintenance plumbing may be facilitated by the new "Permacel" ribbon-type dope, a pipe thread sealant made of DuPont's "Teflon" (fluorocarbon resin). This tape is wrapped around pipe threads and the sections are screwed together. One wrap-around of this material takes the place of the traditional dope can. The tape is unaffected by temperatures from —450° to +500° Fahrenheit, is immune to weathering or aging, and is nontoxic.

ALEXIS TARUMIANZ

NEW FILM ON DEPRESSIONS

the diagnosis and treatment of

DEPRESSIONS *in private practice*

Prepared and narrated by S. Bernard Wortis, M.D., Dean of the School of Medicine and Post-Graduate Medical School, Chairman and Professor of the Department of Neurology and Psychiatry, New York University Medical Center

This timely teaching film is now available for showing to interested professional groups.

The film describes and illustrates the signs of depressions commonly seen in general medical practice, and outlines suggested plans of treatment by the family physician. Suggestions are given on methods of handling suicide risk, referral, treatment in consultation, and hospitalization.

The film is black and white, sound-on-film, runs about 20 minutes and contains no commercial material.

To arrange for a group showing, please write the date you wish to show the film (list alternate dates, if possible) and the number of physicians expected to attend.

Mail your request to:

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REVIEWS & COMMENTARY

READERS' FORUM

Sight Unseen

The picture and short article, "Patients Help Santa Claus" on page 30 of the December issue of MENTAL HOSPITALS, unintentionally hit on one of my "pet peeves." The picture shows personnel from a hospital and local agencies inspecting toys made by the patients. I think this picture is an accurate one, *i.e.*, the hospital personnel and representatives of organizations surround the finished toys, while the patients who have made these items rarely see the children receive the toys. I am willing to make the value judgment that this practice is wrong. If no better arrangement can be worked out, many hospitals have rooms with one-way vision mirrors (whose function is usually well known to patients) where small groups of patients could see some of the toys given to small groups of children. With more regressed patients, personnel could point out explicitly, "You made possible the smiles on the face of those children."

After registering my complaint, I do want to mention how very much I enjoy the contents of MENTAL HOSPITALS. I consider this publication an outstanding forum for creative thinking and a constructive force in the improvement of hospital practices.

WILMA J. KNOX, Ph.D.
Clinical Psychologist
VA Hospital, Sherman, Wyoming

FILM REVIEWS

APPRAISAL OF COMPETENCY (color, 18 minutes) Produced by Nebraska Psychiatric Institute, Omaha.

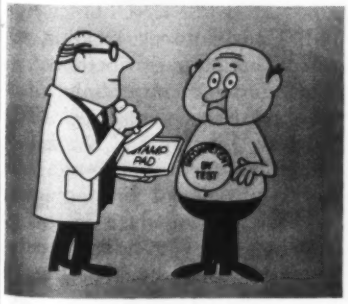
Another excellent training film has been produced by the enterprising film-makers of NPI. Intended for showing to physicians, "Appraisal of Competency" is the first in a series entitled "The Doctor and the Law," and its objective is to clarify a few points for doctors who may be asked to give opinions as to the competency of patients. The "instructor" is our old friend, Dr. Whatsisname, who appears not only in his familiar cartoon form, but also disguised as Henry A. Davidson, M.D. Both are considerably more than competent.

In live action sequences, the genial and highly informative Dr. Davidson explains that competency is a legal concept and not a medical diagnosis. Since there is no way to prove a patient is competent, the doctor must seek to determine whether the patient is incompetent. Incompetency implies, first of all, a disorder of thinking. Next, it implies impaired judgment. Finally, as a result of the impaired judgment, there must be evidence of one of three pragmatic criteria of incompetency.

Dr. Davidson suggests three key words for listing these criteria: "squandering," "gullibility," and "hoarding." As he explains his meaning, a series of amusing animated-cartoon sequences depict various examples of behavior which illustrate his points. Dr. Davidson emphasizes that no one psychiatric diagnosis is a determinant of competency; each case must stand on its own feet. He also points out the curious implications caused by the amount of money involved. If no estate is involved, there is no need to determine competency at all.

Thus it may happen that a patient is competent on Monday, but may have to be declared incompetent on Tuesday—*if* he inherited a million dollars on Tuesday. In all questions involving competency, Dr. Davidson warns that there is no place for the hunch. Instead, the doctor must ask himself three questions: What is the diagnosis? Has this condition adversely affected this patient's judgment? Does the patient meet any of the three pragmatic criteria (hoarding, squandering, and gullibility)?

The wry humor of some of Dr. Davidson's comments is neatly underscored by the caricatures in the



These stills are taken from the animated sequences of Appraisal of Competency. In No. 1, Dr. Whatsisname rubber-stamps his patient as competent. No. 2 illustrates the gullible patient's daydream of squandering money. The composite picture at right shows how animation produces motion by a series of hand positions.

animated sequences, although this does not detract from the film's serious purpose. The result is a lucid presentation that makes "Appraisal of Competency" a useful film for showing to medical societies or to medical students. In his film debut, Dr. Whatsisname shows definite promise. One hopes that his many duties will not prevent him from making more of the same. For information about availability of this film, please write to Audio-Visual Aids Section, Nebraska Psychiatric Institute, Omaha, Nebraska.

BEYOND THE SHADOWS (color, 26 minutes) Produced by the Colorado State Department of Public Health. Available on a loan basis from many state health department film libraries, or may be obtained from the Children's Bureau, U. S. Department of Health, Education, and Welfare, Washington 25, D.C. Persons who intend to purchase prints should address requests for a preview print to Health Education Section, Colorado Department of Public Health, 4210 E. 11th Avenue, Denver.

The increasing interest in mental deficiency has resulted in a number of good films on the subject. Because each new film emphasizes one aspect of deficiency, all of them are useful. "Beyond The Shadows" will be especially welcome to those who have been searching for a film which looks at mental deficiency as a *community* problem. This excellent addition to celluloid "literature" presents a simply-stated explanation of mental deficiency, offers a historical analysis of attitudes toward it, and shows how guilt and ignorance have prevented communities from coping intelligently with the problem. This important background material is presented clearly and interestingly through imaginative art work and a well-written script.

Most of the film, however, is a demonstration of how one community—through self-initiated effort—overcame its fear and prejudice and united in a program to assist its mentally handicapped. In Colorado Springs, parents got together to help mentally deficient children who were unable to benefit from local special education or state institutions. With assistance from the State Department of Public Health (working with the City-County Health Department), and various agencies and individuals in the community, they eventually opened "Hope House," a day-care center for the mentally handicapped.

The film clearly indicates that responsibility for providing special services of this type rests squarely upon the community; that is where concern must be generated and action must be started. It creates no false impression that Colorado Springs has solved *all* of its problems related to the mentally deficient, but emphasizes that community cooperation is necessary before tackling the next one. Another virtue of the film is its depiction of the help supplied by a wide variety of people: pediatricians, public health nurses, psychologists, speech therapists, et al.

"Beyond the Shadows" may be used effectively to encourage parents to work together to obtain special services for their mentally deficient children. It may be shown to inform the general public of problems connected with mental deficiency, and to mobilize support for day-care centers and sheltered workshops. Students of medicine, psychology, and social work will find the film interesting as a public health approach to one special problem.

JACK NEHER
Mental Health Materials Center

CURRENT STUDIES

THE PSYCHOLOGICAL AND MEDICAL ASPECTS OF THE USE OF NUCLEAR ENERGY. This report of the proceedings of two symposia was published by the Group for the Advancement of Psychiatry. The participants—four scientists of international repute in nuclear energy, and one eminent journalist—had already done much to alert the public to the dangers inherent in the use of atomic energy. Among the topics covered are: psychological aspects of the nuclear arms race, implications of the fall-out problem; confusions in the radiation field; the concern of science with nuclear developments; and the implications of nuclear energy for our civilian economy.

PREVENTIVE PSYCHIATRY IN THE ARMED FORCES: WITH SOME IMPLICATIONS FOR CIVILIAN USE. Critical loss of manpower and inefficiency of employees because of psychiatric difficulties may be reduced if preventive techniques developed by military psychiatrists are applied to industry and other organized groups. This is a conclusion set forth in a special report (No. 47) by the Group for the Advancement of Psychiatry. The 48-page report traces the development of preventive techniques in military psychiatry, emphasizing the periods during World War II and the Korean War. Evidence included in the report indicates that the low rate of psychiatric discharge during the Korean conflict as compared with that during WW II was the effect of superior preventive psychiatric programs.

Copies of this pamphlet and of The Psychological and Medical Aspects of the Use of Nuclear Energy, mentioned above, can be obtained for 75¢ each from Publication Offices, Group for the Advancement of Psychiatry, 104 E. 25th Street, New York 10, N. Y. Quantity rates are available upon request.

SOURCES OF INFORMATION ON BEHAVIORAL PROBLEMS OF ADOLESCENCE—An Index of Scientific Studies and Their Sources Dealing with Youth from Ages 14 to 22. This 96-page document was compiled by the A.P.A. Committee on Academic Education with the professional assistance of Prof. Vaclav Mostecky of the Harvard Law Library and his staff. It contains a directory of American institutions engaged in youth research; a directory of current bibliographical services useful in youth research; an analysis of the coverage of journal articles on youth by standard indexing and abstracting services; a list of periodicals pertinent to the study of youth; and a bibliography of youth research. Copies of this booklet can be obtained from the Publications Department, American Psychiatric Association, 1700 18th St., N.W., Washington 9, D. C., at $3 a copy.

BOOK REVIEWS

PROCUREMENT AND MATERIALS MANAGEMENT FOR HOSPITALS—by Rex H. Gregor and Harold C. Mickey, Springfield, Ill., Charles C Thomas, 1960, 159 pages, $7.50.

This informative manual of hospital purchasing procedures, theories, and policies is the first of its kind. While its main emphasis is on purchasing functions in *general* hospitals, the opening sections will be of interest to those in the mental hospital field as well.

The prevailing concept of purchasing as a "service" function has been redefined by the authors as "materials management." This point of view contrasts sharply with practices in many hospitals and raises some provocative questions. How many public mental hospitals fully utilize purchasing sections to predict, plan, direct, and schedule all elements in the field of procurement; to establish product standards, prepare specifications, organize inventory controls, and coordinate the actions of others who share in these responsibilities? How many hospitals have amplified the purchasing function to the point where the procurement officer has become the key consultant in purchasing policy, conducts "value analysis," settles "make-or-buy" questions, chairs the anti-waste committee, and otherwise "obtains the maximum ultimate value for each dollar of expenditure"?

A systematic review of prerequisites for effective, judicious purchasing policies stresses the importance of the procurement officer's conduct to good public relations. Injunctions are issued against such practices as revealing a vendor's prices to his competitors, accepting gift-bribery, and making purchases for members of the hospital staff. The purchaser should never deliberately play off one supplier against another, but is urged to secure a sufficient number of bids. He should also assume responsibility for inspecting the goods received at his hospital.

Assuming that all hospitals need, or can afford, the delicacy of cost accounting, the authors submit a utopian analysis of a purchasing-cost-accounting department with all the requisite paraphernalia; stock and cost inventory cards in colors to identify principal disbursal accounts; separate purchase-control cards in matching colors for cumulative record of receipts; traveling requisitions in matching colors for each stock item; color-coded departmental monthly expense-cards; and, as a corollary, modern posting machines. Naturally, monthly and yearly cost recapitulations *should* flow easily from records kept in this manner.

In the realm of contracts and legal matters, a solution is offered to the problem of when a shipment should be subject to "risk of loss" on the part of the buyer, and when it should be assumed by the seller. A sample purchase-order form illustrates how this can be stipulated

unmistakably in a clause which states that title of ownership passes to the hospital only after it has received the goods.

The book's concluding section offers suggestions for prudent purchasing, and advice concerning specifications, quality, and durability. There are also discussions about purchasing bedding and linen, canned fruits and vegetables, and fresh produce; planning the equipment for a new hospital; and the purchase and care of surgical instruments, including a 50-page appendix of instruments grouped under 44 surgical specialties.

EDWARD H. ALLPORT

OBSERVATIONS ON THE TREATMENT OF THE MENTALLY ILL IN EUROPE—by J. F. Casey, M.D., Leon L. Rackow, M.D., and August W. Sperry, The Veterans Administration, U. S. Government Printing Office, Washington 25, D. C., July, 1960, 63 pages.

During the past few years many new concepts and improved techniques have been introduced into the treatment of mental illness in Europe. From time to time a few small groups of psychiatrists and other professional people have gone abroad for first-hand observation of them. One group, sent by the VA, authored this well-written, easily-read pamphlet. It reports a detailed six-week study of psychiatric practice and procedures in Great Britain, France, Switzerland, Belgium, The Netherlands, Denmark, and Sweden.

This reviewer, having gone on a similar mission two years ago, can state that the authors give a clear, concise, and accurate report of what they saw. They also present some worthwhile conclusions concerning possibilities of absorbing certain European practices into American psychiatry.

Their astute observations encompass such topics as the open hospital, the comparative use of insulin coma and electric shock in Europe and in this country, the philosophy of the value of remunerative work for patients, and the differences in concepts of psychotherapy that exist in the countries they visited.

Much of the pamphlet deals with the care of mental patients outside the hospital, including outpatient services, day and night hospitals, hostels, and domiciliary care programs. The authors were particularly interested in observing care and treatment programs for the elderly. They give excellent accounts of the Worthing and Chichester Experiments in lowering the admission rate to mental hospitals through screening, and the Mapperley Hospital-City of Nottingham plan for prehospital screening of elderly patients.

The second section of this two-part booklet briefly reviews conferences held in the different VA Medical Areas to discuss the authors' observations and how they could be implemented for use by the VA. The entire report will interest and stimulate anyone who is involved in the care and treatment of emotionally ill people.

WILLIAM F. McLAUGHLIN, M.D.

Although depression is a common component of problems seen in medical practice, the classical symptoms of depression are seldom obvious. Much more frequently, depression lurks in the background... is often masked by physical symptoms such as fatigue, insomnia, poor appetite and weight loss ... is frequently detectable only by careful questioning.

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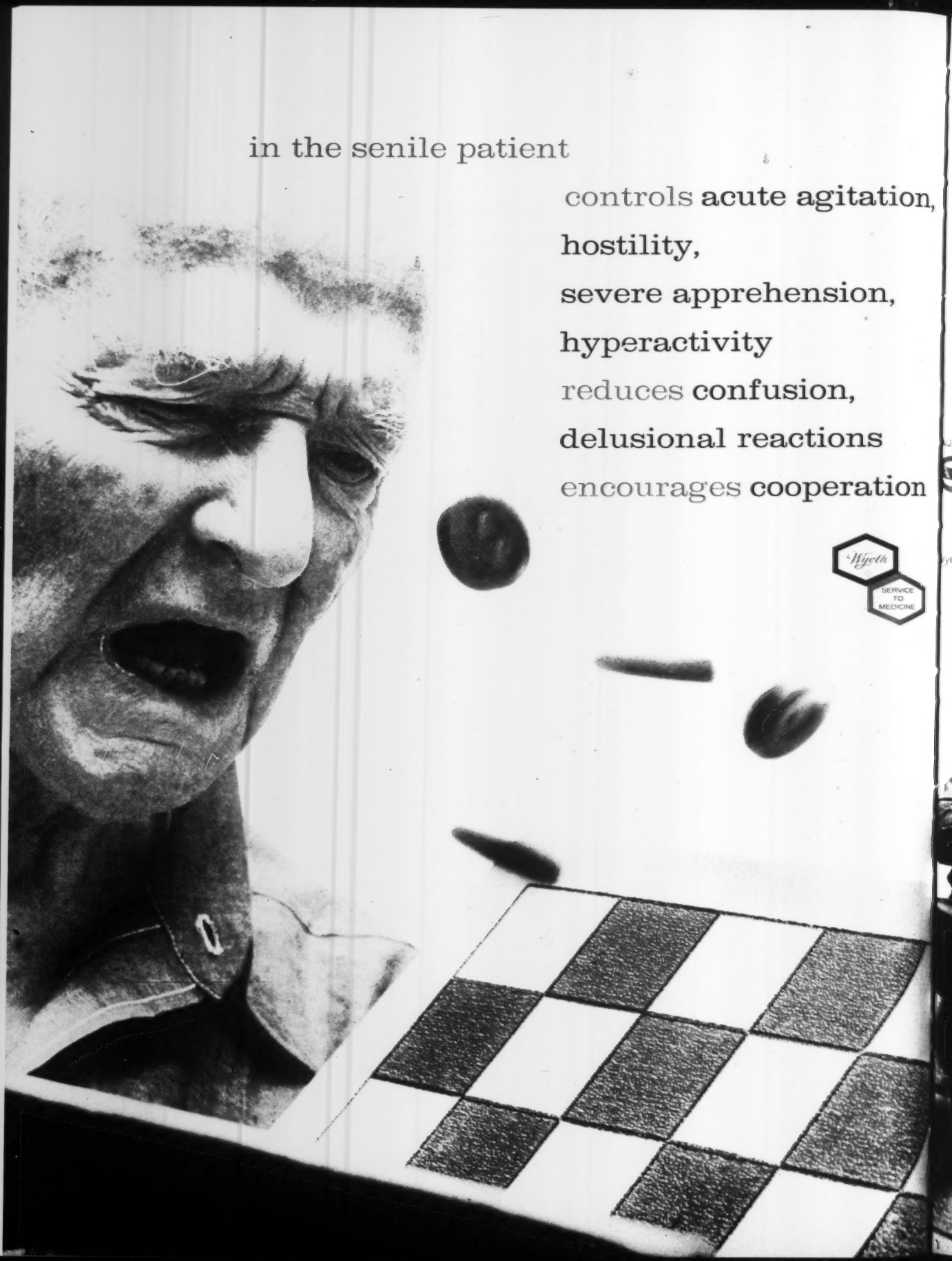
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SPARINE effectively controls central nervous system excitation, allays apprehension and anxiety, calms the agitated patient and is a useful adjunct to the management of mental and emotional disturbances. Both acute and chronic psychiatric illnesses respond to SPARINE therapy. SPARINE has been found to be useful in the management of nausea and vomiting of either central nervous system or gastric reflex origin. SPARINE effectively facilitates the action of analgesics and central nervous system depressants. It has been used as an adjunct to surgical sedation, allaying apprehension and reducing the dosage requirements for narcotics, analgesics and sedatives. SPARINE may be used as an aid in diagnostic and therapeutic regimens. Such nonspecific symptoms as anxiety, pain, vomiting, nausea and hiccups frequently make more difficult both diagnosis and therapy of organic disease. SPARINE allays such symptoms without masking physical, neurological or laboratory findings.

DIRECTIONS. For maximal therapeutic benefit the amount, route of administration and frequency of dose should be governed by the severity of the condition treated and the response of the patient. Oral administration should be used whenever possible; parenteral administration should be reserved for uncooperative patients or when nausea and vomiting interfere with oral administration. SPARINE *when used intravenously should not exceed a concentration of 25 mg. per cc.: injection should be given slowly.* Dilute 50 mg. per cc. concentration with equivalent volume of physiological saline before I.V. use. Avoid injection around or into the wall of the vein.

In the management of agitated patients. SPARINE should be given I.V. in initial doses of 50 to 150 mg. If the desired calming effect is not apparent within 5 to 10 minutes, additional doses up to a total of 300 mg. may be given. Once the desired effect is obtained, SPARINE may then be given I.M. or orally in maintenance doses of 10 to 200 mg. at 4 to 6 hour intervals. *In less severe disturbances,* initial oral therapy may be satisfactory. When tablet medication is unsuitable or refused, SPARINE Syrup may be used.

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For further information on prescribing and administering SPARINE, *see descriptive literature, available on request.*

NEWS & NOTES

13th Mental Hospital Institute
Alfred H. Stanton, M.D., chairman of the Program Committee for the 1961 Mental Hospital Institute, has announced that Cecil Wittson, M.D., will serve as chairman of the Local Arrangements Committee. Members of Dr. Wittson's committee are: John Aita, M.D., and Thaddeus P. Krush, M.D., both of Omaha, and James Mahoney, M.D., of Council Bluffs, Iowa.

The Ladies' Committee under the chairmanship of Mrs. LaVern C. Strough, assisted by Mrs. Cecil Wittson and Mrs. Kenneth Muehlig, is planning special entertainment for the wives of those attending the Institute.

Quarterly Calendar

A.P.A. ANNUAL MEETINGS

1961 May 8-12, Hotel Morrison, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Hotel Sheraton-Fontenelle, Omaha, Neb. (13th)
1962 Sept. 24-27, Hotel Americana, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Cincinnati, Ohio (Hotel to be announced) (15th)
1964 Sept. 28-Oct. 1, Hotel America, Boston, Mass. (16th)

OTHER PROFESSIONAL MEETINGS

AMERICAN ASSOCIATION OF PSYCHIATRIC CLINICS FOR CHILDREN, Annual Meeting, *March 22*, New York City (Inq. 250 W. 57th St., N.Y.C. 19.)
ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS—Annual Karen Horney Memorial Lecture, *March 22*, New York Academy of Medicine.
AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, Annual Meeting, *March 22-25*, Statler-Hilton Hotel, New York City.
AMERICAN SOCIETY OF GROUP PSYCHOTHERAPY & PSYCHODRAMA, Annual Meeting, *March 24-25*, Hotel Commodore, New York City.
NATIONAL ASSOCIATION OF RECREATIONAL THERAPISTS, INC., Annual Meeting, *April 4-7*, Pick-Carter Hotel, Cleveland, Ohio.
CARIBBEAN CONFERENCE FOR MENTAL HEALTH—3rd Annual Conference, *April 4-11*, University College, Mona, Jamaica, B.W.I.
NATIONAL LEAGUE FOR NURSING, Biennial Convention, *April 10-14*, Cleveland, Ohio.
GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, Annual Meeting, *April 13-16*, Hotel Berkeley Carteret, Asbury Park, N. J.
AMERICAN ACADEMY OF GENERAL PRACTICE, Annual Scientific Assembly, *April 17-20*, Miami Beach Auditorium, Miami Beach, Fla.
SOCIETY OF MEDICAL PSYCHOANALYSTS, Academic Lecture, *April 19*, Medical College, New York City.
ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOANALYSIS, Annual Meeting, *April 26*, Karen Horney Clinic Bldg., 329 E. 62nd St., New York City.
AMERICAN PSYCHOSOMATIC SOCIETY, Annual Meeting, *April 28-30*, Atlantic City, N. J.
MENTAL HEALTH WEEK, *April 30-May 6*.
AMERICAN ASSOCIATION ON MENTAL DEFICIENCY, Annual Meeting, *May 2-6*, Netherland-Hilton Hotel, Cincinnati, Ohio.
AMERICAN PSYCHOANALYTIC ASSOCIATION, Annual Meeting, *May 5-8*, Palmer House, Chicago, Ill.
ACADEMY OF PSYCHOANALYSIS, Annual Meeting, *May 6-7*, Hotel La Salle, Chicago, Ill.
ACADEMY OF GROUP PSYCHOTHERAPY & PSYCHODRAMA, Annual Meeting, *May 7*, Morrison Hotel, Chicago, Ill.
AMERICAN SOCIETY OF MEDICAL PSYCHIATRY, Annual Scientific Session, *May 7*, Morrison Hotel, Chicago, Ill.
AMERICAN ACADEMY OF CHILD PSYCHIATRY, Annual Meeting, *May 7*, Palmer House, Chicago, Ill.
ASSOCIATION OF MENTAL HOSPITAL CHAPLAINS, Annual Meeting, *May 8-12*, Sheraton Hotel, Chicago, Ill.
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, Annual Meeting, *May 12*, Morrison Hotel, Chicago, Ill.

Next Certification Examination
Francis J. O'Neill, M.D., secretary of the A.P.A. Committee on Certification of Mental Hospital Administrators, announces that the next examination of candidates will take place on May 7, 1961, in Chicago, Illinois, just prior to the Annual Meeting of the A.P.A. For further information and application form, write to Dr. Francis J. O'Neill, Senior Director, Central Islip State Hospital, Central Islip, New York.

Eyewitness Account
Continuing its inservice education program, the staff of the A.P.A. Central Office received a first-hand report on psychiatry's participation in the White House Conference on Aging from Hayden H. Donahue, M.D., and Mathew Ross, M.D., co-chairmen of the section on mental health (see page 16 for full report). Drs. Donahue and Ross described their part in the conference and expressed their pride in the manner in which various members of the A.P.A. participated.

Other recent talks in the inservice program have included one by Dr. Ross on clinical psychiatry and one by William F. Sheeley, M.D., on diagnostic nomenclature.

Apologies
Seems as though the January issue was a hard-luck one for the staff of MENTAL HOSPITALS. On page 16 the director of volunteers of the Colorado State School was erroneously credited with formulating some basic purposes of orientation for young volunteers. Our apologies to the director of volunteers at the Columbus (Ohio) State School, who is the actual author of the formulation.

Our apologies also to the Kalamazoo (Mich.) State Hospital for not including it as the source of one of our January cover photos. The teenage Gray Lady and Gray Man in the right center picture are from Kalamazoo.

PEOPLE & PLACES

NEW YORK: The **New York Psychoanalytic Society** celebrated its Fiftieth Anniversary at the beginning of February. This society organized the first formal psychoanalytic training in the country in 1925 and established the New York Psychoanalytic Institute in 1931. The institute is now the largest training center of its kind in the world.

Dr. M. Ralph Kaufman, director of the department of psychiatry at Mt. Sinai Hospital, New York City, has been elected vice president of the New York Academy of Medicine.

A new organization called the **Federation of Mental Health Centers, Inc.,** with offices in New York City, has been formed by a group of psychiatric clinics and psychotherapy treatment centers. It has been organized for the purpose of aiding communities to meet their mental health needs, and to provide a medium through which clinics may exchange ideas and practices for their mutual benefit. Dr. Herbert M. Rosenthal was elected president of the federation.

PENNSYLVANIA: **Dr. John MacIver** has been named assistant medical director of the U.S. Steel Corporation, Pittsburgh.

Dr. Alfred P. Noyes, director of psychiatric education, Pa. state mental hospitals, and past president of the A.P.A., recently received the Third Annual Nolan D. C. Lewis Award for his "Outstanding Contributions to Psychiatry."

HERE & THERE: **Delaware State Hospital** (M. A. Tarumianz, M.D., supt.) is one of three psychiatric hospitals selected by the World Federation for Mental Health, for a preliminary research project on employee attitudes toward mental illness. The other two hospitals are in England and in Hawaii respectively.

Ancora State Hospital, Hammonton, N. J., (H. H. Brunt, Jr., M.D., med. dir.) is working with the local mental health association to organize evening education classes for patients. Area school teachers have volunteered their services as instructors.

Dr. Robert S. Spencer has recently been confirmed as director of the new and enlarged Hawaii Division of Mental Health which now includes the Hawaii State Hospital and all mental health clinics on the islands. **Dr. W. J. T. Cody** is the medical director of the Hawaii State Hospital.